



Health Clearance Form

Name: _____	Social Security # _____
Date of Birth _____ Sex _____	Phone (____) _____
Home Address _____	E-mail _____

Parent/Guardian _____	Phone (____) _____
Emergency Contact _____	Phone (____) _____
Family Doctor _____	Phone (____) _____
Address _____	Date of last exam: _____
Insurance _____	Policy number _____

Please check the appropriate box. Comment on all "yes" answers, include dates if applicable

<u>YES</u> <u>NO</u>	<u>COMMENTS</u>
Have you ever had or do you now have:	
Chest pain with or after exercise?	_____
Dizziness with or after exercise?	_____
High blood pressure?	_____
Racing of the heart/irregular rhythm?	_____
Wheezing/cough with exercise?	_____
Weakness, fatigue or anemia?	_____
Hearing loss or perforated eardrum?	_____
Headaches or migraines?	_____
Impaired vision, wear glasses/contacts?	_____
Hernia?	_____
Speech impairment?	_____
Breathing Conditions?	_____
Have you ever had:	
Loss of consciousness?	_____
Concussion?	_____
Convulsions (seizures) or epilepsy?	_____
Neck or back injury?	_____
Any other medical conditions not listed above	_____

Is there any reason the individual cannot participate in a program of education requiring physical activity?

Are there any recommended accommodations needed for this individual? (optional)

List medications currently taking _____

List any Allergies _____

IMMUNIZATION RECORD

Dates

There are several immunizations required for specific programs and housing. Listed below are the immunizations required by program: BIO – Biomedical, RT – Radiologic, VT-Veterinary Science, and Housing. Please note if your program is not identified you are not required to show proof of immunization.

1. Tetanus/Diphtheria _____
2. MMR (Measles, mumps, rubella) _____
3. Polio _____
4. Chickenpox _____
5. 2-Step Tuberculosis (BIO & RT) 1st shot date:_____ read date:_____
2nd shot date:_____ read date:_____
6. Hepatitis series* (BIO & RT) 1)_____ 2)_____ 3)_____
7. Rabies (VT)* 1)_____ 2)_____ 3)_____
8. Meningococcal (Housing) _____
9. CPR (RT) _____

* TB shot is good for one year from date it is read. If TB test is positive a chest x-ray must be performed and the report must be attached to the clearance form.

* Both the Hepatitis B and the Rabies vaccines are a series of three shots. Please place the dates of the each inoculation in the appropriate space and provide appropriate documentation.

* The Tuberculosis test must be complete yearly prior to any clinical practicums for Biomedical and Radiologic students.

I certify that I have examined the above named applicant and the statements are correct.

Physician's Name (print) Physician' s Signature

License # of Physician State of License Date of Examination

Address City State Zip Telephone Number