Kankakee Community College

Physical Exam for Health Career Students

TO THE STUDENT: Placement in a clinical/lab within a health career program is conditional in that you must be physically capable and emotionally stable to perform the essential functions required in the specific program with or without reasonable accommodation, and be free from communicable diseases in the opinion of your physician. A medical examination by a legally qualified healthcare provider is required. **The examination must be complete and on file in the Health Careers Division prior to the first day of classes. You must submit documentation of titer results and immunizations with this physical exam form.** Physicals cannot be older than **four months** from your first day of classes.

Name: _____ Date: _____

Address: _____ Phone no.: ( ) _____

City: _____ Date of birth: _____ Age: _____

Student ID no.: _____ Sex: ❑ Male ❑ Female

Notify in case of emergency: Name: _____ Phone no: ( ) _____

Health Career program or course:

❑ Associate Degree Nursing
❑ Practical Nursing
❑ EMT–Basic
❑ Paramedic
❑ Medical Laboratory Technology
❑ Phlebotomy
❑ Physical Therapist Assistant
❑ Radiography
❑ Respiratory Therapist

PHYSICAL EXAMINATION (To be completed by the Healthcare Provider)

Every student in a Kankakee Community College Health Career Curriculum is required to have a physical examination in order to comply with state health laws governing institutions of higher learning and institutions which provide health services to the public. Please complete this report with that in mind.

Height: _____ Weight: _____ Pulse: _____ Blood pressure: _____

Are there any abnormalities of the following systems (Circle YES or NO)

1. Skin	YES	NO	8. Abdomen	YES	NO	13. Conversational hearing	YES	NO
2. Lymph nodes	YES	NO	9. Genito-urinary	YES	NO	14. Past major illness/injury	YES	NO
3. ENT	YES	NO	10. Metabolic (Endocrine)	YES	NO	15. History of allergy	YES	NO
4. Eyes	YES	NO	11. Neuropsych	YES	NO	16. Color blindness	YES	NO
5. Neck	YES	NO	12. Now under treatment:					
6. Lungs	YES	NO	Medical	YES	NO			
7. Heart	YES	NO	Emotional	YES	NO			

Any other findings? _____

Is this student able to participate in a full program of physical activities?

Circle: YES NO LIMITED. If "no" or "limited," explain.

_____

Does the applicant have any communicable disease which should prevent him/her from providing health services?

Circle: YES NO If "yes," explain.

_____

To your knowledge, is this person taking medication(s) of any kind that would affect his/her safety or full participation in a clinical setting or which could compromise the safe care of patients?

Circle: YES NO If "yes," explain.

_____

Please send this form with the student as soon as the Physical Exam portion (Page 1) is complete. Immunization and titer requirements can be completed and verified at a later date.

Signature of physician/healthcare provider indicates confirmation of physical assessment and above information.

Healthcare provider's name: _____

(Print or type)

Healthcare provider's signature: _____ Date: _____

Address: _____ Phone no.: ( ) _____

Please attach appropriate documentation of immunization and titer records.
Titers are a requirement of the clinical facilities and must be completed regardless of immunization history.

❑ **Measles Titer** – *Lab results must be attached**

❑ **Mumps Titer** – *Lab results must be attached**

❑ **Rubella Titer** – *Lab results must be attached**

❑ **Varicella Titer** – *Lab results must be attached**

* If any of the above titers demonstrate nonimmune or equivocal results, immunization boosters will be required to participate in clinical. You may contact your physician or medical facility where you had the titer completed and they will assist you in determining the process that needs to be followed.

❑ **Tetanus Booster** – *Attach documentation (must be within the last 10 years).*

❑ **Two-step TB received within the last year.** *Attach documentation (Four trips to the facility of your choice are required to complete this lab test).*

Documentation must show 1st and 2nd readings.

1st step: date given _____ date read _____ results _____ mm

Signature _____

2nd step: date given _____ date read _____ results _____ mm

Signature _____

Results must be recorded in "mm" induration. If TB test is from your employer, documentation needs to be on company letterhead or the form used at the facility. A tine test cannot be substituted. If you test positive, contact the county health department for the screening process.

❑ **Hepatitis B** *(All three) – Attach documentation*

#1 Date: _____ #2 Date: _____ #3 Date: _____

Signature _____ Signature _____ Signature _____

OR

❑ Hep B Titer – Lab results must be attached.

❑ **Influenza vaccination** – *will be required during influenza season. Attach documentation.*

❑ **COVID-19** – *Attach documentation: Copy of vaccination card or printout from your state's Immunization portal.*

Facilities in which students must complete their clinical experience may require KCC to release certain student information as a condition for placement. The student information includes, but is not limited to: criminal background check, drug screen results, CPR certification, physical form, and immunization records. This authorization is for the duration of active enrollment in a health career program.

I agree to authorize KCC to release the above documentation as requested by clinical facilities. I understand that failure to agree to this release of information may prevent me from participating in a clinical experience, and thus completing necessary Health Career program requirements.

Name: _____ Date: _____

Student signature (parent/guardian if applicant is under legal age)

WHERE TO RETURN THE COMPLETED FORM/DOCUMENTATION

EMT-Basic, Paramedic, Phlebotomy, Practical Nursing, Registered Nursing: KCC Health Careers Division Office (Room W102).

Medical Laboratory Technology, Radiography, Respiratory Therapist Program, Physical Therapist Assistant: Program clinical coordinator.