Medical Form

WUHS

Name _____ DOB _____ Student ID _____

Address _____ Cell Phone _____

Email _____

Medical History to be completed by student (must be completed before physical-List positive on reverse)					
	Yes	No		Yes	No
Any Past Injuries			Presently Taking Medications		
Allergies			History of Head Injury		
Asthma			Significant Past Illness		
Wears contact lens/glasses			Tuberculosis or Hepatitis (Explain if Yes)		
Past Surgical Procedures			Any Ongoing Medical Problems		
Any Hospitalizations			Seizures		
Fainting or Dizziness While Exercising			Bone/Joint Problems		

Immunization				Titer Date	Result
Diph-Tetanus Booster (dates)					
MMR Vaccine (dates)					
Hep Vaccine (dates)					
Varicella Vaccine (dates)					
PPD (date given)		PPD (Date Read)		PPD (results)	

Physical Exam

Height_____ Weight _____ Blood Pressure _____ Pulse _____

	Normal	Comment/Follow-up		Normal	Comment/Follow-up
General Condition			Gastrointestinal		
Skin			Lungs		
Ears			Gentio-urinary		
Eyes			Neurological		
Nose			Muscloskeletal		
Throat			Spinal		
Mouth/Dental			Nutritional Status		
Cardiovascular			Mental Health		

I certify this student is in good health, free of contagion and able to engage in activities as a health care worker.
Additional Comments: _____
_____

PNP Signature _____
Date _____
License No. _____

Physician Signature _____
Date _____
License No. _____