## 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.

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|--|---|--|---------------------------------------|----------------|----------------|--|--|----------|------------|----------|
| Name:  |   |  |                                       |                | Date:          |  |  |          |            |          |
| Address:   |   |  |                                       |                | Phone no.: ()  |  |  |          |            |          |
| City:  |   |  |                                       |                | te of bi       | rth: .   |  | _ Age    | :          |          |
| Student ID no.:  |   | Sex:   | Ale Femal                             | le             |                |  |  |          |            |          |
| Notify in case of emergency: Name:   |   |  |                                       |                | Phone no: ()   |  |  |          |            |          |
| Health Career program Associate Degree Nurs Practical Nursing                                | -Basic I Medical Laborato<br>medic I Phlebotomy |  | atory To                              | ory Technology |                | <ul> <li>Physical Therapist Assistant</li> <li>Radiography</li> <li>Respiratory Therapist</li> </ul> |  |          | t          |          |
| PHY  | SICAL EXAN                                      | /INATIO  | ON (To be comple                      | ted by         | the He         | alth   | care Provider)   |          |            |          |
| Every student in a Kanka<br>order to comply with state<br>to the public. Please com          | health laws go                                  | verning in   | stitutions of higher                  |                |                |  |  |          |            |          |
| Height: Weight:  |   | Pulse:   |                                       |                | — В            | lood   | pressure:  |          |            |          |
| Are there any abnormaliti  | es of the follow                                | ing syste  | ms (Circle YES or N                   | 1O)            |                |  |  |          |            |          |
| I. SkinYESNO2. Lymph nodesYESNO3. ENTYESNO4. EyesYESNO5. NeckYESNO6. LungsYESNO7. HeartYESNO |   | <ol> <li>Abdomen</li> <li>Genito-urinary</li> <li>Metabolic (Endocrine)</li> <li>Neuropsych</li> <li>Now under treatment:<br/>Medical<br/>Emotional</li> </ol> |                                       | YES<br>YES     | NO<br>NO<br>NO | 14.<br>15.   | Conversational he<br>Past major illness<br>History of allergy<br>Color blindness | s/injury | YES<br>YES | NO<br>NO |
| Any other findings?  |   |  |                                       |                |                |  |  |          |            |          |
| Is this student able to par<br>Circle: YES NO LIMI   |   |  |                                       | es?            |                |  |  |          |            |          |
| Does the applicant have a Circle: YES NO If "ye  | •   | ıble disea   | ase which should pr                   | revent l       | nim/her        | from   | n providing health   | service  | es?        |          |
| To your knowledge, is this<br>clinical setting or which c<br>Circle: YES NO If "ye           | ould compromi                                   |  |                                       |                | ld affec       | t his  | /her safety or full p  | oarticip | ation ir   | ۱a       |
| Please send this form wit titer requirements can be  | completed and                                   | verified   | at a later date.                      |                |                |  | ·  |          |            |          |
| Signature of physician/I   | nealthcare prov                                 | vider ind  | icates confirmatio                    | on of pl       | nysical        | asse   | essment and abo  | ve info  | ormatic    | n.       |
| Healthcare provider's n  | ame:  |  | (1)                                   |                |                |  |  |          |            |          |
| (Print or type) Healthcare provider's signature: Date:                                       |   |  |                                       |                |                |  |  |          |            |          |
| Healthcare provider's si   | gnature:  |  |                                       |                |                |  | Date:  |          |            |          |

Address:

Phone no.: (\_

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)

Please return this form to: Kankakee Community College Health Careers Division office - Room W102