**Student Health Record**

Part 1

Health History (to be completed by the student)

1. Biographical Information Student ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (local): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (permanent): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (cell):\_\_\_\_\_\_\_\_\_\_\_ Phone (permanent): \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (local): \_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_ Race/Ethnic Origin: \_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_ Children (how many): \_\_\_

1. Emergency Contact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone: \_\_\_\_\_\_\_\_\_\_

1. Present and Past Health Status *for asterisked items, if none, please state “none”*

\*Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Medications: Prescribed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the Counter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Previous Surgery(ies): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Chronic Illness/Condition(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Restrictions or limitations on function: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if you have a history of the following. Indicate the year experienced or diagnosed.

□ Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Headaches\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Mononucleosis\_\_\_\_\_\_\_\_\_\_\_\_

□ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Hearing Disorders\_\_\_\_\_\_\_\_\_\_ □ Muscular Disorder\_\_\_\_\_\_\_\_\_

□ Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Heart disease\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Rheumatic Fever\_\_\_\_\_\_\_\_\_\_

□ Epilepsy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Hepatitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Skeletal/Joint Disorders\_\_\_\_\_

□ Emotional Disorder\_\_\_\_\_\_\_\_ □ Lung Disorders\_\_\_\_\_\_\_\_\_\_\_\_ □ Visual Disorders\_\_\_\_\_\_\_\_\_\_\_

□Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that the information provided in this Student Health Record is accurate to the best of my knowledge. I understand that I will not be allowed to participate in clinical education experiences if the health record is incomplete and/or all immunizations are not properly documented. I also understand that all health-related information will be treated confidentially by the program and that it will be my responsibility to release any health-related information to the clinical site upon request.

Student signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Part 2 **Physical Examination (To be completed by MD, DO, PA, or APRN)**

|  |  |
| --- | --- |
| Student Name: | Date of Birth (mm/dd/yyyy): |
| Height: | Weight: |
| Pulse: | Blood pressure: |
| Vision: OD 20/\_\_\_ OS 20/\_\_\_ OU 20/\_\_\_ | Vision corrected: □ YES □ NO |
| Color Vision: □ Normal □ Abnormal | Auditory (whispered word test): □ Normal □ Abnormal |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal | Abnormal | Comments |
| Skin/Hair/Nails |  |  |  |
| Head |  |  |  |
| Ear/Nose/Throat |  |  |  |
| Neck |  |  |  |
| Chest and Lungs |  |  |  |
| Heart/Peripheral Vascular |  |  |  |
| Abdomen |  |  |  |
| Back |  |  |  |
| Hernia |  |  |  |
| Musculoskeletal |  |  |  |
| Neurological |  |  |  |

Limitation of activity? □Yes □No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical health condition that would hinder progress through a physical therapy program? □Yes □No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examiner’s Name (printed) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examiner’s Signature Examiner’s Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examiner’s Address (Street/City/State/Zip)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examiner’s Telephone