Cincinnati State Health and Public Safety Division
Student Physical Evaluation Form

Last Name	**First Name**	**Middle Initial**
Date of Birth (MM/DD/YYYY)	**Student ID**	

1) **Did you conduct a physical exam**? Yes ☐ No ☐

2) **Is this individual free of communicable diseases** that would prohibit direct patient care in a healthcare or homecare setting? Yes ☐ No ☐

3) We need to know if there are any findings that would limit or prevent this individual from fulfilling assigned work duties related to direct patient care. These duties may include moving and positioning patients, bending, performing therapies, patient assessment, airway management, BLS, standing or walking for up to 12 hours, and being able to manipulate equipment with small parts. Based on your physical examination, **is it your qualified opinion that this student can perform these or other related patient care duties without limitation or restriction?**

☐ Yes ☐ No

Please list any restrictions and any reasonable applicable accommodations that would need to be made to allow for direct patient care: _____

_____

4) **Is this individual able to wear a respirator mask?**

Yes ☐ No ☐

_____
Name and title of physician or qualified personnel (Please print)

_____
Signature of physician or NP Date

_____
Telephone Number

_____
Address

IMMUNIZATIONS

Please fill out this form and additionally submit a copy of all vaccination and lab value records. An annual Flu Vaccination is also required and is submitted separately.

Hepatitis B: #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

OR Positive Titer: Date _____ Result _____

Varicella: Varicella Vaccination: Dates #1 ____/____/____ #2 ____/____/____

OR Positive Titer: Date ____/____/____ Result _____

Tdap: (Tetanus, Diptheria, & Pertussis) Date (must be after 2005): Date ____/____/____

MMR: (Measles, Mumps, Rubella), one of which must be 1980 or later:

Dates: #1 ____/____/____ #2 ____/____/____

OR Positive Titer: Date ____/____/____ Results: Measles ____ Mumps ____ Rubella ____

TB Test: If you have not had a 2 step TB test within the past year, a recent 2 Step Tb Test is required. If you have had a TB test in the past year, provide documentation of last year's test and then only a 1 step is required for this year. You may alternatively submit a Quantiferon Gold test in place of a 1 or 2 step test.

#1 Date Applied ___/___/___ Date Read ___/___/___ Result _____mm Signature & Title _____

#2 Date Applied ___/___/___ Date Read ___/___/___ Result _____mm Signature & Title _____

OR 1 Quantiferon Gold blood test: Date ___/___/___ Result _____ Signature & Title _____

If positive PPD reaction, the positive PPD test result AND a recent chest x-ray showing no evidence of active TB must be submitted
(results attached) _____ Yes

_____
Signature of physician or NP Date

Student:
I certify that the information above is true and complete to the best of my knowledge. I understand that it is my responsibility to immediately notify my Program Director or Clinical Coordinator of any relevant change in my overall health while I am enrolled my Program. I authorize Cincinnati State to release this information, as necessary, to any clinical facility utilized as part of my educational experience, or in the event of an emergency.

Students must supply this original form and attached copies of lab documentation and keep a copy for their records. The Program Director will **NOT** copy immunizations or re-furnish immunization documentation to students for their own records, or for third parties (e.g. employers).

_____
Student Signature Date