Texas County Technical College

Health Physical for Healthcare Related Program

Name of Student _____ Date _____
DOB ____/____/_____ Allergies _____
Height _____ Weight _____
T _____ P _____ R _____ BP_____
Immunization Status: (Please give last current date)
MMR _____ PPD ____/____/_____ Results_____mm induration
CXR (if + PPD); results _____
Tetanus _____ Hep B #1 _____, #2 _____, #3 _____ (Recommended)
Head _____
Mouth _____
Speech _____
Ears _____ Hearing_____
Eyes _____
Vision:
☐ Snellen Screening: Right_____ Left_____
If limited, please define limitations: _____
_____
Nose _____ Throat _____
Chest _____ Heart _____
Lungs _____ Skin _____
Musculature & Mobility _____ Endurance _____
Impairments? Yes _____ No _____
If yes, please explain: _____
_____
If yes, would this impairment prevent the student from participating in classroom or clinical activities during the school year? Yes _____ No _____
Eye/Hand Coordination _____
Fine Motor Skills _____
Gross Motor Skills _____
Are there any limitations to the above essential functions that would inhibit the student from participating in classroom or clinical activities? Yes _____ No _____
If yes, please define the limitation and describe in what way the student would be limited:
_____
_____
Past Medical History: (If Pertinent)
_____
_____
_____
_____

Health Physical: (Choose one) **Satisfactory** ☐ **Unsatisfactory** ☐

_____ _____
Signature of Physician or Coordinating Nurse Practitioner Date

Revised 9-9-14