Monroe Community College
STATE UNIVERSITY OF NEW YORK

Health Related Program Physical Exam

First year students **are required to upload** this completed physical exam form and submit official proof of immunizations for MMR, Varicella, Tetanus, Meningitis (may decline), Hepatitis B (may decline), TB/Tuberculosis testing, and Covid -19 vaccine. Note: Check with your specific program to see if the Covid -19 Vaccine is *required* to attend clinicals.

If you are not current with these requirements, you will not be allowed to attend your clinical course until you are compliant. This may result in needing to take the course at another time and not progressing in your program of study.

***Note**: Students who have a condition (impairment) which could interfere with the performance of their essential duties, should connect with MCC's Disability Services to determine what accommodations would be reasonable in a clinical setting.*

Physical Exam - to be completed by Health Care Provider

Physical Exam Date (must be within one year): _____

Student's Name: _____ Date of Birth: _____

Health Related Program (check):

◯ **Clinical Lab Tech** ◯ **Dental** ◯ **EMT** ◯ **Nursing** ◯ **Paramedic** ◯ **Rad Tech** ◯ **Surgical Tech**

Height:_____Weight: _____Blood Pressure:_____Pulse: _____

Uncorrected Vision: Right _____ Left_____ Corrected Vision: Right_____ Left _____

Hearing: _____

Restriction on Physical Activity: _____

Medications: _____

Allergies: _____

TB testing (PPD or IGRA) may be done- must be within past 6 months. *If the student has a known past positive with negative chest-x-ray, a copy of that report is needed- no repeat chest x-ray required.*

For PPD: Date placed: _____ Date read: _____ Read in mm: _____ Result: _____ (*If current PPD results are > 10mm or IGRA is positive, a follow-up chest x-ray report is required.)*

For IGRA: Please attach copy of lab results to this physical.

I certify that the above student/patient is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risk to patients or other personnel or which may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This individual is able to participate in clinical learning experiences as a student in a Health Professions Program.

Select one option below:

◯ Yes ◯ Yes, with my recommendation for further evaluation / treatment: _____ ◯ No

Health Care Provider's Signature or Stamp (with Title): _____

Print Health Care Provider's Last Name: _____

Office Phone: _____ Office Fax: _____