WEBBER International University

Bachelor of Science in Nursing (BSN)
PHYSICAL EXAMINATION & IMMUNIZATION VERIFICATION FORM

STUDENT INFORMATION		
Name:		Date:
Address:		
City:	State:	Zip:
DOB:	**Gender:**	**Heights:**
Pulse:	**BP:**	**Weight:**

PHYSICAL EXAMINATION

HEALTH HISTORY: To be completed by applicant. Please describe all problems you have or have had.

Yes	*No*		*Yes*	*No*	
☐	☐	1. Eye or vision problems	☐	☐	13. Foot problems
☐	☐	2. Ear or hearing problems	☐	☐	14. Headaches or seizures
☐	☐	3. Mouth or teeth problems	☐	☐	15. Skin rashes, lesions
☐	☐	4. Nose, throat	☐	☐	16. Urinary problems
☐	☐	5. Cough, sputum, difficulty breathing	☐	☐	17. Rectal problems
☐	☐	6. Breast lumps, enlargements, nipple drainage	☐	☐	18. Female: vaginal
☐	☐	7. Heart disease/hypertension	☐	☐	19. Male: prostate problems
☐	☐	8. Swollen lymph nodes	☐	☐	20. Emotional illness
☐	☐	9. Indigestion, pain, or food intolerance	☐	☐	21. Diabetes
☐	☐	10. Bowel-constipation, diarrhea	☐	☐	22. Allergies
☐	☐	11. Back pain or surgery	☐	☐	23. Chemical dependency abuse
☐	☐	12. Muscle pain, weakness	☐	☐	24. Other _____

TO BE COMPLETED BY A LICENSED HEALTH PRACTITIONER (M.D., D.O., P.A., A.R.N.P.)

TO THE PHYSICIAN: The above applicant is requesting this health examination and is enrolled in the Bachelor of Science in Nursing Program at Webber International University. The purpose of the examination is to ascertain whether the applicant's health is adequate to enter occupational programs requiring physical and emotional stamina and contact with patients in clinical settings. Should you have questions regarding the form, please call Bachelor of Science in Nursing Program at 863-638-2922. The Health History should be completed by the applicant, prior to the physician's examination. **Thank you for your assistance.**

TO BE COMPLETED BY PRACTITIONER. Describe any abnormalities, in the space provided below.

Normal	**Abnormal**		**Normal**	**Abnormal**	
☐	☐	1. Ears, Hearing	☐	☐	10. Lower extremities
☐	☐	2. Oral Cavity: hard/soft palate	☐	☐	11. Feet and arches
☐	☐	3. Nose, throat sinuses	☐	☐	12. Reflexes
☐	☐	4. Lungs	☐	☐	13. Skin
☐	☐	5. Heart-size, rhythm, sounds	☐	☐	14. Posture
☐	☐	6. Lymph nodes	☐	☐	15. Breasts (optional)
☐	☐	7. Abdomen	☐	☐	16. Genitalia (optional)
☐	☐	8. Back	☐	☐	17. Anus (optional)
☐	☐	9. Upper extremities	☐	☐	18. Pelvic exam (optional)

Visual Exam:

Distance: R _____ L _____ Both ___ Glasses: ☐ Yes ☐ No

Near: R _____ L _____ Both ___ Contact: ☐ Yes ☐ No

Color Perception:_____

IMMUNIZATION VERIFICATION

Does the applicant have a history of hepatitis? ☐ Yes ☐ No

Has the applicant received any type of hepatitis vaccine? ☐ Yes ☐ No If yes, date:_____Type:_____
Hepatitis B vaccine is strongly recommended.

DECLINATION OF HEPATITIS B VACCINATION-I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been advised of the importance of the Hepatitis B Vaccine. However, I decline the hepatitis B vaccination currently. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future if I continue to have exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series.

Student Signature_____ Date:_____

Immunization Record (Required)

Tuberculin Test (Within 6 months) Date: _____ Result: ( ) Positive ( ) Negative If positive, chest x-ray is required (Within 2 years)	**Tetanus Toxoid/Booster** Date: _____ (Within 5 years)	**MMR** (if earlier than 1969, requires booster) Date: _____ **- OR -** **Rubella Titer:** Date: _____ Copy of Rubella Titer results must be attached to this form.	**Varicella Titer** Date _____ Copy of Varicella Titer results must be attached to this form.	**COVID-19** ☐ Yes ☐ No ☐ Moderna ☐ Pfizer ☐ J & J ☐ Other_____ 1st dose:_____ 2nd dose:_____

To the best of my knowledge, applicant appears to be free of infectious disease. ☐ Yes ☐ No

Has applicant had any medical/surgical problems that have required treatment in the past 2 years?
☐ Yes ☐ No If yes, date: _____ If yes, describe:

Please list any ***medications***, which the patient is taking on a continuing basis:

PHYSICIAN COMMENTS: Include any additional significant information concerning health findings and/or treatment for health occupation applicants.

_____

_____

_____

_____

Based on your examination, do you consider the applicant mentally and physically able to undertake the essential functions required by the Baccalaureate Occupational Therapy Assistant Program at Webber International University? ☐ Yes ☐ No

PLEASE PRINT, TYPE OR STAMP NAME AND ADDRESS OF HEALTH PRACTITIONER IN THE BLOCK BELOW:

_____ _____ _____
Health Practitioner Signature License Date

_____ _____
Health Practitioner Name (Printed) Health Practitioner's Phone Number

_____ _____ _____
ADDRESS: Street City State Zip Code