SANTA BARBARA CITY COLLEGE

Health Technologies Programs Physical Exam Form

Name _____
Student ID #_____
Height_____ Weight_____
BP_____
Program_____

Distant Vision		Near Vision	
Uncorrected	Corrected	Uncorrected	Corrected
O.D._____			
O.S. _____			
Color Vision_____			

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE COLUMN	DESCRIPTION OF ANY ABNORMALITIES
		Eyes	
		Ears – (Tympani, Canals, Discharge)	
		Nose	
		Mouth (teeth)	
		Throat (tonsils)	
		Neck	
		Chest (include breasts)	
		Lungs	
		Heart	
		Abdomen	
		Extremeties	
		Varicose Veins	
		Feet (arches)	
		Spine (alignment, R.O.M.)	
		Neurologic	
		Skin/Scars	
		Rectal/Vaginal if indicated by history	
R_____L_____	R_____ L_____	Hearing	
YES	NO	Is Hernia present?	
YES	NO	Does applicant appear healthy & alert?	

ALL IMMUNIZATIONS AND PHYSICIAN'S SIGNATURES ARE REQUIRED

Take proof of immunizations to your medical exam for verification

Required			
	TB Skin Test (must have been done within 12 months of beginning program) **Date given:**_____ **Date read:**_____**Results:** _____		Signature:
			Signature:
	If TB skin test is positive, chest x-ray is required	Date:	Signature:
	MMR (Measles, Mumps, Rubella Vaccination)	Date:	Signature:
	If MMR immunization records are not available, the following titres are required:		
	Rubella Titre Results:	Date:	Signature:
	Rubeola Titre Results:	Date:	Signature:

Recommended: Hepatitis B Vaccine: Date 1st _____ 2nd _____ 3rd _____ Signature:_____

1. Do you believe that this individual is and will likely be mentally and physically capable of pursuing a Health Technology program? Yes_____ No_____

If No, please explain_____

_____

2. Does he/she have any health related condition that would create a hazard to him/herself, fellow employees, patients, or visitors? Yes_____ No_____

If Yes, please explain_____

_____

Signature _____**M.D. Date**_____

PHYSICIAN'S STAMP & ADDRESS

Please submit completed form to: SBCC, Health Technologies Office, 721 Cliff Drive, Santa Barbara, CA 93109-2394

3/08