



Saint Joseph Hospital Radiography Program is dedicated to providing a quality education for individuals in the field of radiologic technology. The program incorporates the core values of Catholic Health Initiatives, which includes reverence, integrity, compassion and excellence. Our mission is to produce competent technologists for the various aspects of the profession.

## TO THE STUDENT:

For admission into the Saint Joseph Hospital Radiography Program, it is required that this physical form is on file upon admission into the program. Your family physician or any physician of your choice may do this examination.

Last Name	First	Middle/other	
Street Address	City	State	Zip
Home Telephone	Age	Date of Birth	

## STUDENT MEDICAL HISTORY:

Check each box below yes or no and indicate year for each yes response.

Have you had/have the following? \_\_\_\_\_

Yes	No	Condition	Year	Yes	No	Condition	Year
<input type="checkbox"/>	<input type="checkbox"/>	Asthma		<input type="checkbox"/>	<input type="checkbox"/>	Mumps	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis		<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Care		<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy		<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures		<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	
<input type="checkbox"/>	<input type="checkbox"/>	Severe Headaches		<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	
<input type="checkbox"/>	<input type="checkbox"/>	Measles		<input type="checkbox"/>	<input type="checkbox"/>		

Please note any other past medical problems: \_\_\_\_\_

I verify that the above medical information is correct to the best of my knowledge.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

- over -

**TO THE PHYSICIAN:**

Please complete the following Medical Examination. This examination is at the student's expense.

Additional History and Medical Examination:

Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In.      Weight: \_\_\_\_\_ lbs.      Blood Pressure: \_\_\_\_\_      Pulse: \_\_\_\_\_

Vision: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_      Corrected to: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_

Physician's comments on Medical History: \_\_\_\_\_

Illnesses, injuries, or hospitalizations not previously noted: \_\_\_\_\_

Surgical (Major Operations): \_\_\_\_\_

Is patient allergic to any medications?       Yes       No

If yes, indicate medications: \_\_\_\_\_

Is patient currently taking any medication(s)?       Yes       No

If yes, list name of drug(s), dosage, strength and frequency: \_\_\_\_\_

Note any pertinent physical abnormalities: \_\_\_\_\_

Has patient lived in a household with anyone who has had tuberculosis?       Yes       No

If yes, explain: \_\_\_\_\_

Test/Vaccine	Date	Results	Test/Vaccine	Date	Results
MMR			HEP-B		
MMR			HEP-B		
RUBELLA SCREEN			HEP-B		
RUBEOLA SCREEN			HBSAb		
Tdap			Varivax		
PPD					

Certification of Medical Examination

This is to certify that I have examined \_\_\_\_\_ and find him/her free of any communicable disease(s) and also any physical limitations that might interfere with performing his/her duties as a radiography student.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date of Examination

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Physical or medical limitations on the physical examination are subject to a request for additional information to clarify disabilities or limitations to facilitate a suitable placement.