Saint Joseph Health System
Radiography Program

# Physical Form

Saint Joseph Health System 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 Health System 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 |
|---|---|---|---|---|---|---|---|
| | | Asthma | | | | Mumps | |
| | | Tuberculosis | | | | Chicken Pox | |
| | | Mental Health Care | | | | Heart Murmur | |
| | | Epilepsy | | | | Heart Disease | |
| | | Convulsions/Seizures | | | | Rheumatic Fever | |
| | | Severe Headaches | | | | High Blood Pressure | |
| | | Diabetes | | | | Hay Fever | |
| | | Measles | | | | | |

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.