Los Angeles Skills Academy

Physical Exam Form

Medical Education Student Physical Exam Form

Student's name _____ Today's date_____

Date of birth _____ Age_____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column.

GENERAL HEALTH:	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection ☐ Seizures Other:		
2. Ever had surgery?		
HEAD/NECK/SPINE:	**YES**	**NO**
3. Had headaches with exercise/exertion?		
4. Ever had a head injury or concussion?		
5. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
6. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
7. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
8. Been prescribed glasses or contact lenses?		
HEART/LUNGS:	**YES**	**NO**
9. Uses an inhaler or takes asthma medicine?		
10. Ever had a doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
11. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded **DURING** or **AFTER** exercise?		
12. Had discomfort, pain, tightness or chest pressure during exercise/exertion?		
13. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT:	**YES**	**NO**
14. Had a broken or fractured bone, stress fracture, or dislocated joint?		
15. Had an injury to a muscle, ligament, or tendon?		
16. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
17. Had joints that become painful, swollen, feel warm, or look red?		
SKIN:	**YES**	**NO**
18. Had any rashes, pressure sores, or other skin problems?		
19. Ever had MRSA skin infection?		

GENITOURINARY:	YES	NO
20. Had groin pain or a painful bulge or hernia in the groin area?		
21. **FEMALES ONLY:** PREGNANT **If student is pregnant, OBI GYN healthcare provider signature is required for enrollment due to lifting.** **SIGNATURE:**		

Student Functioning	YES	NO
22. **Strength.** Student must be able to perform physical activities requiring ability to push/pull objects more than 50 pounds and to transfer objects of more than 100 pounds [with assistance].		
23. **Manual Dexterity.** Student must be able to perform motor skills such as standing, walking and handshaking, and manipulative skills such as writing and calibration of equipment		
24. **Coordination.** Student must be able to maintain body coordination such as walking, retrieving equipment; hand- eye coordination such as keyboard skills; and tasks which require arm-hand steadiness such as taking blood pressure, calibration of tools and equipment, etc.		
25. **Mobility.** Student must be able to perform mobility skills such as walking, standing, and occasionally prolonged standing or sitting in an uncomfortable position		
26. **Tactile.** Student must have tactile ability sufficient for physical assessment. Must be able to perform palpation, functions of physical examination and/or those related to therapeutic intervention.		
27. **Conceptualization.** Student must be able to understand and relate to specific ideas, concepts and theories generated and simultaneously discussed.		
28. **Memory.** Student must be able to remember tasks/assignments given to self and others over both long and short periods of time.		
29. **Critical Thinking.** Student must possess critical thinking ability sufficient for clinical judgment. Must be able to apply theoretical concepts to clinical settings.		
30. **Interpersonal.** Student must have interpersonal skills sufficient to interact with individuals, families and groups from a variety of social, emotional, cultural and intellectual backgrounds.		
31. **Communication.** Student must be able to communicate effectively during interaction with others in written and verbal form. Must be able to explain treatment procedures and initiate health teaching		
32. **Substance Abuse.** Student must display no evidence or indication of current alcohol or drug abuse.		

After reviewing the patient's medical history and reviewing program guidelines (please initial one):

_____I hereby certify that this patient has successfully passed examination and is physically able to fully participate.

_____I am not able to approve this patient for full participation in this program.

Name/Title (printed) of HCP

_____

Signature/Title of HCP

_____

Place the HCP/Office or Clinic Stamp in this box please.

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Los Angeles Skills Academy

Tuberculosis Screening Form

Tuberculosis Screening

Student Information

Student Name: _____

Student Address: _____

City:_____State:___Zip:_____Telephone: _____

TB Skin Test

The TB skin test (also called the Mantoux tuberculin skin test) is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm.

A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm. The health care worker will look for a raised, hard area or swelling, and if present, measure its size using a ruler. Redness by itself is not considered part of the reaction. Some people are allergic to the TB skin test or have been infected by the TB bacteria in the past. This means the person's body was infected with TB bacteria. Additional tests are needed to determine if the person has latent TB infection or TB disease. A health care worker will then provide treatment as needed.

Skin Test Information

Administrator Name Title (printed): _____

Date/Time Administered:_____ Left Arm:____ Right Arm:____

Manufacturer:_____Expiration Date:_____Lot #: _____

Results (TST Reading Date Required)

Induration:_____mm Date/Time of Reading:_____

Adverse Reaction/Comments_____

Signature/Title of Reader _____

Or:

TB Blood Test (IGRA)

The TB blood test is another way to screen for TB infection and may be done in place of a TB skin test if recommended by the healthcare provider. A healthcare provider will draw blood and send it to a lab for testing. The lab will report the test results to the healthcare provider. A positive blood test means the person's body was infected with TB bacteria. Additional tests are needed to determine if the person has latent TB infection or TB disease. A health care worker will then provide treatment as needed.

Date of blood test _____

Lab Stamp:

Results: (check box that applies)

___ Negative___Positive

Name/Title of Healthcare Provider: _____

Signature/Title of Healthcare Provider: _____

Or:

Chest X-RAY Information

Individuals with a current or past positive TB screening test should have a chest x-ray to rule out pulmonary TB.
Date of fill

Hospital/Facility where film taken: _____

Interpretation (check the box that applies)

___ Completely Negative

___ Negative, Except for: _____

___ Positive

Radiology Lab/Physician/Clinic Stamp

Name of Radiologist/Physician:_____

Signature of Radiologist/Physician:_____