



DATE: _____

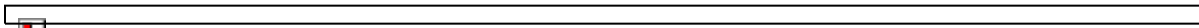
BISMARCK STATE COLLEGE MEDICAL EXAMINATION FORM Surgical Technology

Name: _____
Last First Middle Date of Birth

Home Address: _____ Sex: F M
Street City State Zip

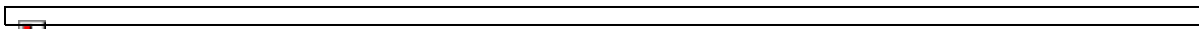
Person to be notified in case of an emergency: _____

Relationship: _____ Address: _____ Phone: _____



PURPOSE OF EXAMINATION

- ▶ To promote early consultation for prevention and prompt care of disease and injury
- ▶ To indicate conditions for which a student should receive further consultation and/or treatment
- ▶ To provide information in case of emergency for a student subject to diabetes, allergies, convulsions, etc.
- ▶ To indicate conditions that may prevent a student from gaining employment in his/her chosen vocation



INSTRUCTIONS TO THE APPLICANT

This information is desired only as an aid in the consideration of your health. It will not affect your college standing.

1. **Physical forms need to be completed and turned in to the Surgical Technology Faculty along with required immunizations.** Physical forms should be completed no more than 3 months prior to the clinical rotation. Forms completed prior to this period will not be honored and the student will be required to submit a current physical form at the student's expense.
2. Please make an appointment with a licensed Nurse Practitioner/Physician's Assistant/Physician of your choice. **The examiner must complete page two and three and sign the form on page three.**
3. The medical examination is a post-admission requirement and is at your expense. Mail or deliver the completed form to:

Bismarck State College
Surgical Technology Program
PO Box 5587
Bismarck, ND 58506-5587

PERSONAL HISTORY

Have you ever lived in close personal contact with anyone who had tuberculosis? No Yes

If yes, explain: _____

Have you or do you now have any of the following? If none, check here

	Yes	No		Yes	No		Yes	No
1 . Heart disease	_____	_____	4. Diabetes	_____	_____	7. Recurrent headaches	_____	_____
2 . Tuberculosis	_____	_____	5. Hernia			8. Other	_____	_____
3 . Asthma	_____	_____	6. blackouts, Convulsions, or nervous tendencies	_____	_____			

If yes, explain: _____

List dates of significant injuries or operations you have had. If none, check here

Injury/Operation	Date	Injury/Operation	Date
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any physical impairment such as paralysis, loss of vision, impaired hearing, back or spine conditions etc.? No Yes

If yes, explain: _____

Are you subject to any of the following?

	Yes	No		Yes	No
1. Sensitivity to any medication such as penicillin, horse sera, etc.	_____	_____	3. Hay fever or asthma	_____	_____
2. Latex Sensitivity	_____	_____	4. Other sensitivity	_____	_____

If other, describe: _____

Have you ever had or are you now receiving treatment for any of the above? No Yes

If yes, explain: _____

Will you need treatment continued for any of these conditions while at school? No Yes

If yes, explain: _____

Are you taking any medication regularly? No Yes if yes, explain: _____

Have you ever been advised against normal physical exercise? No Yes if yes, give advisor, date, and reason:

MEDICAL EXAMINATION

Please review the personal and family history and make such examination as you deem necessary. We strongly urge that tetanus toxoid be given unless protected within the last 10 years. This examination is at the student's expense. We are happy to have your advice in the care of this student while at Bismarck State College.

Explain any conditions you consider significant in the family or personal history: _____

Complete all items, indicating normal by check mark or explaining positive findings.

Height: _____ Weight: _____ Blood Pressure: _____
Cardio-vascular _____
Lungs _____
Hernia _____
Ear, nose and throat _____
Vision _____
Color vision _____ Prescription of glasses if available R _____ L _____
Hearing _____
Nervous system _____
Bone and joint _____

Are the following immunizations up to date?

Tetanus toxoid _____ Polio _____
Varicella _____ Tuberculin _____
Measles, and rubella _____
Hepatitis B _____

Note: the above are strongly advocated.

Note allergies or sensitivities that may be significant. Normal _____

Explain any physical or emotional conditions you consider important. Normal _____

Is this student presently under medical therapy? No Yes If yes, explain:

Is this student capable of normal physical exercise, swimming, or other athletic activity? No Yes if no, explain:

Comments concerning this individual regarding a career in surgical technology:

Nurse Practitioner/Physician Assistant/Physicians Name (Print)

Signature

Date

Medical Facility

Street

City

State