DATE: _____

BISMARCK STATE COLLEGE MEDICAL EXAMINATION FORM

Surgical Technology - DO NOT COMPLETE UNTIL INSTRUCTED TO DO SO BY PROGRAM FACULTY

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 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 fax the completed form to:

Bismarck State College
Surgical Technology Program
500 E Front Ave Suite 261
Bismarck, ND 58504
Fax (701) 255-0167

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. Convulsions, blackouts, 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 toxid _____ 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/Physicians Name (Print) Signature Date

_____
Medical Facility Street City State