Physical Examination to be completed , signed and dated by Health Care Provider

□ Male □ Female

Name | Date of Birth (MM/DD/YYYY) | Gender

Height | Weight | Blood Pressure | Pulse

TB Test

Tuberculin Skin Test: (Mantoux)
Date placed ___/___/___ Date read: ___/___/___

Results: _____mm of induration
Interpretation based on mm of induration and risk factors:
□ Negative □ Positive (Chest X-ray required)

OR

IGRA: (Specify method) _____
Date Tested: ___/___/___

Results: □ Negative
□ Indeterminate/Borderline (repeat)
□ Positive (Chest X-ray required)

Chest X-ray Date: ___/___/___ Results: □ Normal □ Abnormal (explain) _____

Treatment Plan (include information about INH therapy and duration of treatment): _____

Clinical Evaluation	Normal	Record Abnormal Findings
1. Appearance		
2. Skin		
3. Head, Ears, Eyes, Nose, Hearing ,Vision		
4. Mouth, Teeth, Gums		
5. Neck and Thyroid		
6. Lungs/Chest		
7. Breasts		
8. Heart		
9. Pulses		
10. Abdomen		
11. Genitalia		
12. Back/Spine		
13. Extremities/Musculoskeletal		
14. Neurological		
15. Emotional/Psychological		
16. Other Findings		

17. Is this student cleared for full physical activity including participation in physical education and sports?
□ Yes – Unlimited activity □ No – Limited activity Reason: _____

Additional Comments/Recommendations: _____

I have reviewed the medical history and immunizations, conducted the TB screen and examined the student noted above. The information on this physical form is accurate, full and complete to the best of my knowledge.

Signature of Health Care Provider | Date (MM/DD/YYYY)

Print Name of Health Care Provider | Address | Phone | Fax