Quality HealthCare Training, LLC
PHYSICAL FORM

TO BE PRINTED & TURNED IN AFTER ACCEPTANCE

TO BE COMPLETED BY APPLICANT

Name of Applicant: _____
(Print Name)

Date of Birth: _____

Hospitalizations (why and when): _____

_____

STUDENTS: Please check all conditions that apply to you:

☐ Allergies
☐ Arthritis or Rheumatism
☐ Asthma
☐ Back Injuries
☐ Diabetes
☐ Difficult breathing (past moderate exertion)
☐ Dizzy Spells or Fainting
☐ Hearing Problems
☐ Epilepsy or Seizures
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ Migraines or Severe Headaches
☐ Psychiatric Disorder
☐ Surgery
☐ Tuberculosis
☐ Vision Problems (Other than corrected by lenses)
☐ Any other serious illness

State details on conditions checked above: _____

_____

_____

_____

Do you have any limitations that require accommodations to be successful in the program?

_____Do you currently receiving any medical treatment or taking any medications? ☐ Yes ☐ No

If so, please describe treatment and list medications_____

_____

Have you ever been treated for any psychological issues? ☐ Yes ☐ No If yes, when_____

_____

I have revealed my medical history truthfully and wholly. I authorize my medical provider to give information to the QHT Nursing Department regarding my ability to participate in clinical rotations.

Applicant's Signature: _____ Date: _____

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HEALTH CARE PROVIDER TO COMPLETE THIS SIDE Student Name_____

Please check Yes if the applicant's past or present medical history indicated any of the below. Explain if "Yes."

Yes	No	
☐	☐	Chronic Illness_____
☐	☐	Physical Disability_____
☐	☐	Acute Illness_____
☐	☐	Recurring Physical or Mental Health Concerns_____
☐	☐	Visual Impairment_____
☐	☐	Hearing Loss_____
☐	☐	Neck, Shoulder, Back Problems_____

Significant Medical History of Applicant_____

_____

REQUIRED IMMUNIZATIONS

1. 2-Step PPD (within one year) Date: _____ Reaction: _____ Date: _____ Reaction: _____
   Chest x-ray if PPD is positive: Date: _____ Results: _____
2. Diphtheria-Tetanus Toxoid (TdaP) (within 10 years) Date: _____
3. Flu Vaccine (October-March) Date: _____
4. Polio Vaccine: Date: _____ Date: _____ Date: _____ or Booster Date: _____
5. MMR, Varicella, and Hepatitis B – All students are required to verify 2 doses of the MMR and Varicella vaccine and 3 doses of the Hepatitis B vaccine, OR have titers drawn to show immunity.
   a. Rubella Titer – Date: _____ Immune: ☐ Yes ☐ No
   b. Rubeola Titer – Date: _____ Immune: ☐ Yes ☐ No
   c. Mumps Titer – Date: _____ Immune: ☐ Yes ☐ No
      OR 2 doses of the MMR vaccine – Date: _____ Date: _____
   d. Varicella Titer – Date: _____ Immune: ☐ Yes ☐ No
      OR 2 doses of the Varicella vaccine – Date: _____ Date: _____
   e. Hepatitis B Titer – Date Immune Yes No
      OR 3 doses of Hepatitis B vaccine – Date: _____ Date: _____ Date: _____
6. Applicant can perform essential functions of a nurse: ☐ Yes ☐ No

RECOMMENDATION: From the preceding exam, do you believe _____ is capable to undertake all the demands placed on a health care provider? (Student's Name)

Remarks: _____

_____

PRINT Health Care Provider's Name: _____

Address: _____

Phone: _____ Date: _____

Health Care Provider's Signature: _____

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Hepatitis B Virus Vaccine Declination

IMPORTANT:

Before signing this form, please review the CDC's Hepatitis B Vaccine Information Statement at http://www.cdc.gov/vaccines/hcp/vis/vis-statments/hep-b.html.

I have reviewed information on the Hepatitis B disease and the risks associated with Hepatitis B vaccine. I understand that due to my clinical and occupational exposure to blood or other potentially infectious materials, I may be at risk for acquiring Hepatitis B virus (HBV) infection.

Waiver of Immunization:

I have received and reviewed the information pertaining to Hepatitis B. I am aware of the health risks of this disease, the mode of transmission, and possibility of exposure to Hepatitis B to health care professionals. I understand I continue to be at risk of acquiring Hepatitis B but choose to refuse the vaccine at this time. Due to personal, medical, or religious reasons, I am requesting that **Quality HealthCare Training, LLC Waive** the health requirement for immunization against Hepatitis B.

Student Signature: _____

Date: _____

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***MEDICAL EXEMPTION:**

☐ DPT ☐ Td ☐ Tdap ☐ Polio ☐ MMR ☐ Hepatitis B Series ☐ Varicella zoster

As specified in Article 22.1-271.2C. (II) of the Code of Virginia, I certify that administration of the vaccine(s) designated above would be detrimental to this student's health.

The vaccine(s) is (are) specifically contraindicated because: _____

This contraindication is ☐ permanent (or) ☐ temporary and expected to preclude immunization until

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PRINT Physician or Health Department Name_____

Physician or Health Department Official Signature _____

Date: _____ **Phone:** _____

Quality HealthCare Training, LLC does not discriminate on the basis of race, color, national origin, age, sex, religion, or disability in its programs, activities or employment practices.

Return To: Quality HealthCare Training, LLC

25900 Greenfield Road Suite 256
Oak Park, Michigan 48237
Monday - Friday 9 a.m. to 6 p.m.

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