



Hillsborough Community College
Continuing Education
39 Columbia Drive
Tampa, Florida 33606

Phone (813) 259-6509
Fax (813) 253-7156

PHYSICAL EXAMINATION FOR CONTINUING EDUCATION PROGRAMS

Date _____

Name _____
Last First MI

Male _____ Female _____ Date of birth _____

Address _____
Street

City _____ State _____ Zip _____

Telephone (Home) _____ (Cell) _____

Immunization History

Dates of Immunization, Vaccination or Titer

DTP _____

Polio _____

MMR _____

Hepatitis B _____

(Or complete attached declination form)

Tuberculin Test Skin _____ CXR _____ Date _____ Results _____

(Please note, TB skin test must be updated annually)

If TB test positive, follow-up: _____

Height _____ Weight _____ P _____ R _____ B/P _____

Head & Neck	Normal	Abnormal	Comments on Abnormal Findings
Head, scalp	_____	_____	_____
Lids, Sclera	_____	_____	_____
Eye Muscles	_____	_____	_____
Pupils	_____	_____	_____
Fundi	_____	_____	_____
Ears	_____	_____	_____
Nose/Sinus	_____	_____	_____
Teeth/Gums	_____	_____	_____
Pharynx	_____	_____	_____
Thyroid	_____	_____	_____
Lymph nodes	_____	_____	_____
Carotids	_____	_____	_____

Chest	Normal	Abnormal	Significant Health History
Lungs	_____	_____	_____
Heart	_____	_____	_____
Auxiliary Nodes	_____	_____	_____

Abdomen	Normal	Abnormal	Significant Health History
Organs	_____	_____	_____
Hernial rings	_____	_____	_____
Inguinal Nodes	_____	_____	_____

Extremities	Normal	Abnormal	General Comments
Range of Motion	_____	_____	_____
Pulses	_____	_____	_____
Joints	_____	_____	_____

Neurological	Normal	Abnormal	General Comments
Gait	_____	_____	_____
Cranial Nerves	_____	_____	_____
Motor Function	_____	_____	_____
Sensation	_____	_____	_____
Coordination	_____	_____	_____
Mentation	_____	_____	_____

Please note Yes or No to the Following Questions:

- Sufficient mobility to maneuver in small spaces, quickly respond to emergencies, perform physical and repetitive tasks. Yes _____ No _____
- Gross and fine motor abilities Yes _____ No _____
- Visual acuity sufficient for observation and assessment necessary to provide safe nursing care. Yes ___ No ___
- Tactile ability sufficient for accurate physical assessment. Yes _____ No _____
- Mental and emotional stability to tolerate stressful experiences, frequent changes, and unexpected occurrences. Yes _____ No _____

Signature of Examining Health Care Provider

Printed Name of examining Health care Provider

Address of Health Care Provider

HEPATITUS VACCINE DECLINATION

I understand that due to potential exposure to blood or other potentially infectious materials in the clinical settings I may be at risk of acquiring a hepatitis virus infection.

I have been given the opportunity to be vaccinated for hepatitis; however, I decline the vaccination at this time.

Signature

Date

Print Name