



**RADIANS
COLLEGE**

1025 Vermont Avenue, NW
Suite 200
Washington, DC 20005
Tel: 202-291-9020
Fax: 202-291-8013

HEALTH FORM

Last Name

First Name

Date of Birth

Social Security Number

Male Female

PHYSICAL EXAM

Height: _____ Weight: _____ B/P: _____ T: _____ P: _____ R: _____

PE	NORMAL	ABNORMAL	COMMENTS (Describe Abnormal Findings)
GENERAL			
SKIN			
EENT			
LUNGS			
CARDIAC			
ABDOMEN			
BACK			
JOINTS			
NEUROLOGIC			
GU/GYN			____yes ____no EDC____ Pregnant

Other Comments: _____
Is there any reason this individual will not be able to enter the clinical healthcare setting? ____Yes
____No (If yes, please explain.)

Date

Physician's Signature

Physician's Name and Address

[Please use official stamp]

Tel. Number: _____

(PLEASE COMPLETE BOTH SIDES OF THE FORM)

IMMUNIZATION/SCREENING TEST RECORD

Td (Tetanus / Diphtheria): / /
 (Must be within Date Administered
 the past 10 years)

MEASLES/MUMPS/RUBELLA: / / (Laboratory test results
 MMR Immunity Date of Titers Measles Titer Result must be attached)

OR

 Mumps Titer Result

MMR Vaccine / /

 Date Administered

 Rubella Titer Result

TUBERCULOSIS SCREENING: AT LEAST ANNUALLY

PPD Test:

<u> </u> / <u> </u> / <u> </u> Date Administered	<u> </u> / <u> </u> / <u> </u> Date Read	<u> </u> Result	<u> </u> Initials of Physician/Nurse
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<u> </u> / <u> </u> / <u> </u> Date Administered	<u> </u> / <u> </u> / <u> </u> Date Read	<u> </u> Result	<u> </u> Initials of Physician/Nurse
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<u> </u> / <u> </u> / <u> </u> Date Administered	<u> </u> / <u> </u> / <u> </u> Date Read	<u> </u> Result	<u> </u> Initials of Physician/Nurse
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For Positive PPD: Chest X-ray / /
 Treatment, if applicable: Result Initials of Physician/Nurse

VARICELLA (CHICKEN POX): / / (Laboratory test results must
 Date of Titer Titer Result be attached)

OR

VARICELLA Vaccine / /

 Date Administered

HEPATITIS B: (Series of three required)

<u> </u> / <u> </u> / <u> </u> Hep. B I Date	<u> </u> Initials of Physician/Nurse
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<u> </u> / <u> </u> / <u> </u> Hep. B II Date	<u> </u> Initials of Physician/Nurse
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<u> </u> / <u> </u> / <u> </u> Hep. B III Date	<u> </u> Initials of Physician/Nurse
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VDRL (RPR): **REQUIRED ANNUALLY** / /
 Date Result Initials of Physician/Nurse

 Date

 Physician's Signature

 Physician's Name and Address
 [Please use official stamp]
 Tel. Number: