FLAG STAR NURSING

PHYSICAL EXAM FORM

EXAM DATE
/ /

PERSONAL INFORMATION

NAME	D.O.B	S.S.N
ADDRESS		
CONTACT NUMBER	POSITION	GENDER

PHYSICAL EXAM

HEIGHT	WEIGHT	PULSE	BLOOD PRESSURE
HEART	LUNGS	BACK	ABDOMEN
EYES	EARS	NOSE	THROAT
MEDICAL HISTORY			

TUBERCULOSIS SCREENING

1ST PPD	DATE PLACED / /	DATE READ / /	RESULTS / LOT NUMBER
2ND PPD (OPTIONAL)	DATE PLACED / /	DATE READ / /	RESULTS / LOT NUMBER
CHEST X-RAY	DATE	RESULTS	*ATTACH LAB REPORT
QUANTIFERON TB GOLD TEST	DATE	RESULTS	*ATTACH LAB REPORT

LAB TESTS—*ALL LAB REPORTS MUST BE ATTACHED*

MEASELS TITER	DATE	RATIO	IMMUNE / NOT IMMUNE
MUMPS TITER	DATE	RATIO	IMMUNE / NOT IMMUNE
RUBELLA TITER	DATE	RATIO	IMMUNE / NOT IMMUNE
VARICELLA VACCINATION	DATE	RATIO	IMMUNE / NOT IMMUNE
RUBEOLA TITER	DATE	RATIO	IMMUNE / NOT IMMUNE
HEPATITUS B VACCINATION	DATE (DOSE 1)	DATE (DOSE 2)	PATIENT DECLINED
INFLUENZA VACCINATION	DATE		PATIENT DECLINED
DRUG SCREENING	DATE	RESULTS	

BASED ON HEALTH HISTORY AND EXAMINATION / LABS, THIS PATIENT'S CONDITION WILL PERMIT HIM/HER TO WORK IN THE HEALTHCARE FIELD. THIS INDIVIDUAL IS FREE OF ANY HEALTH IMPAIRMENT WHICH IS OF POTENTIAL RISK TO A PATIENT OR WHICH MAY INTERFERE WITH HIS/HER DUTIES INCLUDING THE HABITUATION OR ADDICTION TO DEPRESSANTS, STIMULANTS, NARCOTICS, ALCHOHOL OR ANY OTHER DRUG SUBSTANCES.	☐ FULLY EMPLOYABLE ☐ LIMITATIONS	☐ NOT CURRENTLY EMPLOYABLE

PHYSICIAN'S NAME	PHYSICIAN'S SIGNATURE	DATE	PHYSICIAN'S STAMP

AN ANNUAL PHYSICAL EXAMINATION IS REQUIRED FOR CONTINUED EMPLOYMENT WITH FIVE STAR NURSING

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