PHYSICAL/HEALTH FORM

This form is required to be completely filled out by a primary care provider and returned to Lake Area Technical College before beginning your Healthcare program. Students are responsible for returning all forms.

General Information

Lake Area Tech Program:_____

Full Name (First, Middle, Last):_____

Last 4 digits of Social Security Number:_____ Student ID#:_____ Gender:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Allergies

Is the student allergic to or has had adverse reaction to anything such as medications, foods, latex, plants, insects, animals, etc.? If yes, please explain.

Allergy	Reaction

Latex Advisory

In addition, the individual has been advised of exposure to latex and latex-based products in healthcare environments and the potential health risks for individuals with sensitivities or allergies

INITIAL HERE:_____

Medications

List all medications currently used, including any over the counter medications.

☐ CHECK IF NO MEDICATIONS ARE ROUTINELY TAKEN

Medication	Dose	Frequency	Reason

IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH IT.

Health History

Does the student currently have or has ever been treated for any of the following?

Yes	No	Condition	Yes	No	Condition
◯	◯	Diabetes	◯	◯	Thyroid disease
◯	◯	Head injury/concussion	◯	◯	Hernia
◯	◯	Chronic cough	◯	◯	Urticaria
◯	◯	Tuberculosis	◯	◯	Varicose veins
◯	◯	Fainting spells and dizziness	◯	◯	Drug addiction
◯	◯	Asthma	◯	◯	Alcoholism
◯	◯	Weak back/back surgery	◯	◯	Fallen arches
◯	◯	COPD	◯	◯	Excessive fatigue
◯	◯	Ears/eyes/nose/sinus problems	◯	◯	Seizure disorders
◯	◯	Psychological or emotional difficulties	◯	◯	Hypertension (High blood Pressure)
◯	◯	Behavioral/neurological disorders	◯	◯	Abdominal/stomach/digestive problems

List any other medical conditions not covered above, and/or provide information concerning any boxes checked "yes."	

Physical Examination

Date of Examination_____

Please review the student's history and complete the physical examination. Please comment on all positive answers. This information will be used only as a background for providing evidence that they can meet the demands of their profession. This information is strictly for the use of the Health service and will not be released without student consent.

DOB:_____ Age:_____ Height (inches)_____ Weight (lbs)_____

T/P/R:_____/_____/_____ BP:_____/_____ Color Blindness: ◯ **Yes** or ◯ **No**

Vision Acuity:_____ Vision with Correction (Glasses or Contacts: 20/_____(L) 20/_____(R)

HEENT:_____ Hearing Assessment:_____

Cardiopulmonary:_____ Neurological:_____

Abdominal:_____ Musculoskeletal:_____

Back:_____ Rectal/GU:_____

List any physical limitations noted:

This area should be completed by the Primary Care Provider (the person completing this form).

By signing this form, I verify, that I have reviewed the information on this form, including medical diagnoses (if any) and medications (if any) and found that:

(Student Name)_____

has no health restrictions and may participate in the_____

program at Lake Area Technical College.

*Please add any notes or concerns you have regarding this student and/or if you would recommend re-evaluation or a change of health program

Date of Exam:_____

Printed Examiner's Name:_____

Examiner's Signature:_____

Credentials:_____

Lake Area Tech Students:

Return this completed form to Admissions, PO Box 730, Watertown, SD 57201

Scan and e-mail to: admissions@lakeareatech.edu

Or Fax 605-882-6299

It is the student's responsibility to be sure all forms have been received.

Immunization Form/Requirements

The following immunizations/testing are required for students entering the following Health Programs: Dental Assisting, Medical Assisting, Med/Fire Rescue/Medical Lab Tech, Occupational Therapist Assistant ,Physical Therapist Assistant, Nursing (PN/RN) and Surgical Tech.

- If immunized, check yes and **provide a copy of the immunizations**
- If not immunized or shows no proof, the student should receive the immunization, or receive a titer to determine immunity. **Please provide a copy of immunization(s) and/or labs**
- If choosing to decline any immunizations please fill out and submit the declination form. (obtained from the website, admissions or program administrator.)

MMR (Measles, Mumps, Rubella)

Yes	No
◯	◯

Complete ONE of the following:

*****Two doses of MMR Vaccine

*MMR titer showing immunity

*MMR required of all students born after 1956 per South Dakota Department of Health

Varicella (Chicken Pox)

Yes	No
◯	◯

Complete ONE of the following:

*****Two doses of Varicella vaccine

*Varicella titer showing immunity

Hepatitis B *(PTA excluded)*

Yes	No
◯	◯

Complete ONE of the following:

*****Three doses of Hepatis B vaccine at appropriate interval between shots

*Two doses ONLY if receiving Heplisav-B (HepB-CpG) manufactured by Dynavax, which is approved for two doses, one month apart

*Hepatitis B titer that shows immunity to Hepatitis B

Hepatitis B Titer *(DA & PN/RN only)*

Yes	No
◯	◯

*In addition to any Hepatitis B vaccine a Hepatitis B **titer** is **required** to show immunity.

*If not immune, follow the advice of your healthcare provider

Tetanus, Diphtheria and Pertussis (TDAP)

Yes	No
◯	◯

Complete ONE of the following:

*****One dose of Tdap vaccine within the last 10 years

COVID-19

Yes	No
◯	◯

Complete ONE of the following:

*Pfizer or Moderna - Two doses at appropriate interval between shots

*Johnson & Johnson Janessen - one dose

Tuberculosis (TB)

Yes	No
◯	◯

Complete ONE of the following: (TB tests are offered on campus each fall-for a small fee)

*Proof of a negative two-step TB skin test (The two-step process requires a one-week interval between shots, not to exceed 28 calendar days)

Flu Shot

Yes	No
◯	◯

Current to the year enrolled

Other Requirements:

CPR Card - American Heart Association or American Red Cross Basic Life Support-Health Programs

*Courses are offered on campus periodically. Check with your program advisor for further information