HUNTER BUSINESS SCHOOL
Student Health Examination Record

NAME ____ DATE OF BIRTH _______________________

ADDRESS ____ TELEPHONE # _________________________
Street City, State, Zip

I have read this form and declare that I have no injury, illness or ailment, other than as specifically herein noted, that would not allow me to be employed as a Health Care Professional. Any falsification or misrepresentation will be sufficient grounds for my release from this program.

Student Signature _______________________________________

Blood Pressure __________ Urinalysis __________ Wt. __________ Ht. __________

Operations _____________ Fainting Spells ______ Sinus Trouble ___________________

Fractures ______________ Epilepsy ___________ Skin Disease ____________________

Head Injury ____________ Mental Disease ______ Hypertension ___________________

Back Injury ____________ Jaundice ___________ Heart Trouble ___________________

Chronic Back Pain ______ Rheumatism ________ Stomach Trouble ________________

Tuberculosis ___________ Asthma ____________ Diabetes ________________________

ALLERGIES: Food _________ Environment __________ Medications _____________ Latex ________

PROOF OF IMMUNITY IS REQUIRED FOR ENROLLMENT IN THE PROGRAM
Lab Reports with Titer Levels Must Be Attached

Hepatitis B: 1st dose ___________ 2nd dose ____________ 3rd dose ______________

Rubeola (Titer Level) Immune _________________ Non-Immune ______________________
If not immune, booster is required.

Rubella (Titer Level) Immune ________________ Non-Immune ______________________
If not immune, booster is required.

Mumps (Titer Level) Immune ________________ Non-Immune _____________________
If not immune, booster is required.

Varicella (Titer Level) Immune _______________ Non-Immune _____________________
If not immune, booster (vaccination) is required.

Mantoux (lot #)__________________ Date ______________ Date Read _______________ Result _______

Chest X-Ray_______________________________________ Date _______________ Result _________
(only if PPD is positive)

Only 40 years of age or older must have an EKG ____

DT date of Immunization _________________________________

Ears _____________________ Eyes ___________________ _ Teeth _______________________

Skin _____________________ Scars ____________________ Nose & Throat ________________

Heart ____________________ Lungs ___________________ Abdomen ____________________

Hernia ___________________ Extremities _______________ Menstrual History _____________

Other ____

Are there any pre-existing conditions that may interfere with performance?

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Date ____________________ Examining Physician __________________________________

Address ____

License Number _____________________________________

This section must be totally completed.

STUDENT MUST FILL OUT THIS SECTION

In case of emergency, notify:

Name ____

Address ____
Street City State Zip

Telephone Number ____

Relationship ____