

**Medical Laboratory Technician (MLT) Associate in Applied Science Degree**

**PHYSICAL AND IMMUNIZATION FORM**

# All areas are required to be completed for acceptance as a completed physical for the MLT program.

**STUDENT APPLICANT INFORMATION (to be completed by MLT student applicant):**

Last Name First Name Middle Initial

Home Address (Number and Street) City/Town State Zip Code Date of Birth

Telephone Number Alternate Telephone Number Student’s Social Security #

# IMMUNIZATION INFORMATION (to be completed by the physician):

**To the examining physician:** Comment on all positive answers and indicate date of disease, immunization, or results of immunity lab tests.

**\*Mumps immunization:** must have been received after 1979 or immunity from disease confirmed by a physician.

**\*Tetanus booster:** required documentation of booster if immunization was not within the last ten years.

**\*Tuberculosis testing:** TB test must be current. A baseline 2-step test is required for all students who have not had a previous 2-step. A one step test is required each year thereafter. A negative chest X-ray and yearly physician documentation of negative physical signs and symptoms of tuberculosis is required for any positive TB skin test.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DISEASE** | **DATE OF IMMUNIZATION** | | | **DATE OF DISEASE** | **LAB RESULTS/COMMENTS** |
| **1st** | **2nd** | **3rd** |
| Chickenpox |  |  |  |  |  |
| Measles |  |  |  |  |  |
| \*Mumps |  |  |  |  |  |
| Rubella |  |  |  |  |  |
| Polio |  |  |  |  |  |
| \*Tetanus-Diphtheria  Booster |  |  |  |  |  |
| \*Tuberculosis testing |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |

# Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# PHYSICAL INFORMATION (to be completed by the physician):

Height Weight Blood Pressure Corrected Vision: Right 20/ Left 20/

|  |  |  |  |
| --- | --- | --- | --- |
| **Any abnormalities of the following areas?** | **YES** | **NO** | **IF YES, PLEASE EXPLAIN.**  **(include current treatments)** |
| Head, Ears, Nose, or Throat |  |  |  |
| Eyes |  |  |  |
| Respiratory |  |  |  |
| Cardiovascular |  |  |  |
| Gastrointestinal |  |  |  |
| Genitourinary |  |  |  |
| Hernia |  |  |  |
| Musculoskeletal |  |  |  |
| Metabolic/Endocrine |  |  |  |
| Neurological |  |  |  |
| Psychiatric |  |  |  |
| Skin |  |  |  |
| Lymph Nodes |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **IF YES, PLEASE EXPLAIN.**  **(Attach additional sheets as necessary)** |
| Is there loss or serious impaired function of any organ or limb? |  |  |  |
| Is there any back impairment or lifting restrictions? (need to be able to individually  lift a minimum of 50 lbs) |  |  |  |
| Do you have any recommendations for any  physical or emotional/psychological restrictions? |  |  |  |
| Is there any reason the student cannot  physically or emotionally/psychologically participate in the MLT program? |  |  |  |

Physician’s Signature Date

Print Last Name

Office Address

Office Phone

***Rev’d MLM 7/2021***