

**INSTITUTE OF AMERICAN INDIAN ARTS
GENERAL PHYSICAL EXAMINATION AND LABORATORY TESTS
THIS FORM MUST BE COMPLETED BY A PHYSICIAN OR MEDICAL PROVIDER**

NAME OF STUDENT: _____ Date of Exam _____

Note: ALL ITEMS ARE REQUIRED. Please indicate all findings, normal as well as abnormal.

- Allergies: Indicate if patient has allergies to medications and document the nature of the reaction.
- Conduct the physical exam. Comment on any abnormal findings and indicate what treatment if any was provided.
- Obtain blood pressure, pulse, height and weight.
- Indicate if student is receiving care for a chronic illness or treatment for an emotional disorder.
- Perform the required tests indicating date of test and results.
- The PPD skin test must be placed and read before the student will be allowed to move into campus housing. **NOTE: If PPD is greater than 10mm induration, a chest x-ray must be obtained. If the chest x-ray is abnormal, INH treatment or other TB prophylaxis should be initiated.**
- Physician or medical provider should provide signatures and office stamp verifying completion of exam.

ALLERGIES: Yes No. If yes, to what? PCN Sulfa Erythromycin Other _____

If yes, what is the nature of the reaction? _____

Is this individual currently on any medications? If yes, please list all medicine(s) by name, dosage and purpose of medication

	<i>Normal</i>	<i>Abnormal</i>	<i>Comments (all abnormal findings)</i>
Head and Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgeries/date	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENT	<input type="checkbox"/>	<input type="checkbox"/>	_____

Blood Pressure _____ Pulse _____ Height _____ Weight _____

Is this individual under care for a chronic or serious illness? Yes No If yes, please explain _____

REQUIRED TESTS

	Date	Results
Urinalysis	_____	_____
HGB/HMCT	_____	_____
PPD*	_____	_____

***NOTE: PPD test should be mantoux within the past year (tine or momovac not acceptable). PPD must be placed and read before student will be allowed to move into campus housing. Treatment should be initiated if positive, greater than 10 mm induration and chest x-ray is abnormal. If positive, provide _____ mm indurations (horizontal diameter).**

Note: If greater than 10mm induration, chest X-ray required.

X-Ray results: Normal Abnormal

If chest x-ray is abnormal, has patient begun INH treatment or other TB prophylaxis treatment? Yes No If no, please explain)

Received BCG: Yes No If yes, chest X-Ray required. X-Ray results: Normal Abnormal

PHYSICIAN OR MEDICAL PROVIDER SIGNATURE

Physic _____ Name (Please Print) _____ Signature _____ Phone _____

ADDRESS _____ City/State/Zip _____