



**History and Physical Exam**  
*For **Respiratory Therapy** Technology Program*

Name of Applicant \_\_\_\_\_

Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

**Physical Exam:** To be completed by a physician or trained medical personnel under the supervision of a physician.

| Medical                             | Normal | Abnormal Findings (if any) | Initials |
|-------------------------------------|--------|----------------------------|----------|
| Eyes (Vision)                       |        |                            |          |
| Ears, Nose, Throat                  |        |                            |          |
| Neck/Lymph Nodes                    |        |                            |          |
| Cardiovascular                      |        |                            |          |
| Abdomen/Hernias                     |        |                            |          |
| Respiratory                         |        |                            |          |
| Skin                                |        |                            |          |
| Musculoskeletal                     |        |                            |          |
| Neurological                        |        |                            |          |
| <b>Musculoskeletal/ROM/Strength</b> |        |                            |          |
| Neck                                |        |                            |          |
| Spine/Back                          |        |                            |          |
| Shoulders/Arms                      |        |                            |          |
| Wrist/Hand                          |        |                            |          |
| Hip/Thighs                          |        |                            |          |
| Knees/Legs/Ankles                   |        |                            |          |

- **Allergies:** \_\_\_\_\_
- **List any medications taken frequently:** \_\_\_\_\_
- **Do you have physical activity limitations? If yes, please explain:** \_\_\_\_\_

**Required Tests**

**1. TB Gold**

- If reactive, a Chest X-ray is required

***Please provide the above testing results to the student for submission to the program's Student Upload Portal.***

**2. 10 PANEL EXPANDED OPIATE DRUG SCREEN (either urine or blood is acceptable)**

- Accepted panels:

- Amphetamines
- THC
- Cocaine
- Opiates
- Barbiturates
- Phencyclidine
- Benzodiazepines
- Methadone
- Oxycodone
- MDMA/ecstasy
- Fentanyl
- Methaqualone
- propoxyphene

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***Please provide the above testing results to the student for submission to the program's Student Upload Portal.***

I certify that I have examined and spoken to this patient on this date and found them to be medically qualified to participate both physically and emotionally in the ***Respiratory Therapy program***. I also certify that I am a licensed physician or work directly with a licensed physician.

Print Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date of Examination \_\_\_\_\_

**\*\*\*Cost of the physical examination, laboratory tests, and immunizations assumed by the applicant. \*\*\***

**Students:**

**Submit this completed form to the Student Upload Portal found on the Respiratory Therapy webpage.**

**RETURN TO STUDENT FOR DOCUMENT UPLOAD**

*Revised: October 30, 2024*