All Physical Therapy Assistant (PTA) students are required to have evidence of a physical examination within the twelve months prior to beginning their internships. Included with this physical exam should be evidence of the student’s immunization status for measles, mumps, rubella (MMR), and Hepatitis B vaccine status. (See attached form.) Students are responsible for having this physical examination form completed and returned to PRIOR to starting PTA classes. **You will need to perform TB tests (PPD) during or after semester one.** If you have had a TB (PPD) test within 12 months, you will be required to have another as they are only good for one year. This test requires two visits to the physician’s office: one for the initial test and one 48 hours (2 days) later for the test to be read. Thus, be sure to make your appointment on Monday, Tuesday, or Wednesday so you have time to return and have the test read or you will have to pay for a second test.

The student must arrange to have the physical exam completed by their personal physician or clinic. The student is responsible for paying for the cost of the physical.

Completed physical forms and immunization results should be emailed to Maria Vacca @ mvacca@hodges.edu or FAXED to the attention of Maria Vacca @ 1-239-236-1453. **The due date for the January 2016 class is December 11, 2015. You may need to set up your appointment now so you can ensure that you complete the physical in time.**

Remember that it is the student’s responsibility to provide this information **before** the PTA courses begin. **Students who do not have all of this information completed and documented may NOT begin their courses in the PTA program and will forfeit their spot in the program.**
STUDENT HEALTH REPORT
(CONFIDENTIAL)

This form must be completed before a student begins the Physical Therapist Assistant courses.

Name: ________________________________________________________________

Address: ______________________________________________________________

Telephone: _____________________________________________________________

In Emergency Notify: ____________________________________________________

Emergency Telephone: __________________________________________________

The following physical is required of all Physical Therapist Assistant students and must be performed within twelve months prior to starting the PTA Program in January.

Sex ______ Height ________ Weight ________ Blood Pressure _____________

Briefly report on physical examination. Note any handicaps or abnormalities:

Heart: ________________________________________________________________

Lungs: ________________________________________________________________

Abdomen: _____________________________________________________________

Extremities: __________________________________________________________

Are there any significant medical history or chronic conditions? Yes_____ No_____

Please specify and note if this will limit the student’s performance of job, related activities and/or physical activities associated with Physical Therapist Assistant clinical duties.

________________________________________________________________________

________________________________________________________________________
Immunization Status: Please circle Yes or No, Date and Initial.

Immunity of MMR: Yes No Date: _____________ Initials ___________

Hepatitis B Vaccine: Yes No Date: _____________ Initials ___________

If No, Status of Hep B Vaccine: ________________________________

Immunity to Varicella: Yes No Date: _____________ Initials ___________

Flu shot (During Flu Season) Yes No Date: _____________ Initials ___________

In my professional opinion, ________________________________ (Students Name) can perform all required activities associated with Physical Therapist Assistant clinical duties including lifting, pushing, pulling, prolonged standing, and overhead reaching.

Signature of Examiner Completing Report: ________________________________ Date ___________

(Physician, Nurse Practitioner, Physician Assistant)

Print Name of Examiner Completing Report: ________________________________

Address: ____________________________________________________________

Phone Number ______________________________________________________
Hepatitis B Virus Vaccination
(CONFIDENTIAL)

While performing the tasks required during your education, there is a risk of exposure to blood or other potentially infectious materials and you may be at risk of being exposed to Hepatitis B virus (HBV) infection. It is recommended that you receive the Hepatitis B Vaccination series, which includes 3 injections, unless you can demonstrate pre-existing immunity. This series may be obtained at your physician’s office or the local health department. The vaccinations are to be obtained at the student’s expense.

Name: ________________________________________________________________

Dates of Vaccination:

1.) _______________________________ (Provider’s Signature)
    Date

2.) _______________________________ (Provider’s Signature)
    Date

3.) _______________________________ (Providers Signature)
    Date

OR attach a copy of your immunization records or titers.

___________________________________________________________________

___________________________________________________________________