WASHINGTON STATE COLLEGE OF OHIO

HEALTH EXAMINATION BY PHYSICIAN

Medical Laboratory Technology

Name of applicant: _____

Date of birth _____ Weight _____ Height _____

I. <u>Do you have a history of diseases of the following?</u>

Please answer **YES** or **NO**.

If you answer **YES** – please explain:

	Yes	No	Explanation
Skin			
Eyes/Vision			
Eyes – Color Blind Test			
Ears/Hearing			
Cardiac			
Lungs/Respiratory Illness			
Musculoskeletal			
Diabetes			
Neurological/Seizures			
Abdominal (Hernias)			
Vascular (Varicose Veins)			
Allergies			

- List any medication or drugs taken frequently.
  _____
- Physical activity limitations?
  Yes ___ No ___ Explain: _____

II. <u>Please provide dates of either immunization or proof of immunity of the following:</u>

	Proof of Immunity (Titer) or Date of Immunization/s
Measles (rubeola) • 2 live vaccinations after 1st birthday	
Mumps • 2 live vaccinations after 1st birthday	
Rubella (German Measles) • 1 live vaccination after 1st birthday	
T-DAP	**Date of immunization:**
Varicella (Chicken Pox)	

** If you were given the immunization prior to 1975, you may wish to protect yourself by having the immunization repeated.*

** Some clinical affiliates may ask for a titer.*

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III. Required Laboratory Tests

IGRA (TB Gold) DATE _____ RESULTS _____

- (Chest X-Ray PA & Lateral) if IGRA is positive DATE _____ RESULTS _____

10 Panel Expanded Opiates Drug Screen DATE _____
*RESULTS must be submitted to the program director

- **DO YOU CONSIDER THE APPLICANT PHYSICALLY AND EMOTIONALLY ABLE TO UNDERTAKE A PROGRAM IN THE HEALTH SCIENCES? YES ___ NO ___**

REMARKS:

Physician's Name: _____

Office Address: _____

Telephone: _____

Physician's Signature: _____ *Date of Examination:* _____

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

PLEASE SUBMIT THIS FORM TO THE APPROPRIATE PROGRAM:
Washington State College of Ohio
710 Colegate Drive
Marietta, Ohio 45750

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Revised: March 2025