



BCIT ADULT EDUCATION
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PHYSICAL EXAMINATION FOR ALLIED HEALTH PROGRAMS/COURSES

THIS FORM MUST BE RETURNED TO ADULT ED. BY _____
(Return this form for review at least 2 weeks before course start date or on requested date per program)

Following To Be Completed By Student:

Please print all information clearly in the spaces provided. Add supplemental data if necessary.

1. Name _____ Last 4 of SS# _____
Last First Middle Initial.

Address _____
Street City/Town State Zip Code

Phone (w) _____ (h) _____ (cell/other) _____

E-mail _____

Contact In the Case of an Emergency _____
Last Name First Name

Phone # (c) _____ (h) _____ (w) _____ E-mail _____

Following To Be Completed By Physician or Nurse Practitioner:

Please print all information clearly in the spaces provided. Add supplemental data if necessary.
All sections must be completed

2. Is this person being treated for any chronic conditions? If so, please list them below:

Condition

Treatment

Please use the space below to make any comments concerning this individual's health status, including any recommendations you may have regarding her/his physical activities or limitations. Students must receive separate clearance for pregnancy.

NOTE: Each student enrolled in an allied health program must be able to perform all activities required to complete the program; there is no "light duty." Student must be able to lift and move up to 50lbs. (Not Required for Dental Program)

3. All immunizations must be current and completed prior to the start of the Allied Health Program (or as instructed by each program).

Immunizations	Immunity		Date and Result of Titer (Immunity is required)
	Yes	No	
Measles (Rubeola)			
German Measles (Rubella)			
Mumps			
Chicken Pox (Varicella)			
Tdap			
Flu (seasonal)			
*Hepatitis B - Dates vaccine administered			#1 #2 #3
10 Panel Urine Drug Test (Not required for Dental Assisting)			Date: Result:
Copy of Personal Health Insurance			

N.J.A.C. 8: 39-19.5(b) mandates that “each new employee shall,” receive a two-step Mantoux tuberculin test with five units of purified protein derivative. The only exceptions shall be documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within a year, a documented positive Mantoux skin test (10mm or more of induration), those having received appropriate medical treatment for tuberculosis, if medically indicated.

*This mandate is interpreted to include those students who give direct care to those patients who are frail and elderly. Therefore, students must have a two-step Mantoux tuberculin skin test. If the first is negative then the second should be administered one to three weeks later; these will be documented on their physical form.

This test must be completed within one month prior to the start of the program.

Two Step Mantoux Tuberculin Skin Test #1 Date _____ Results _____
 or #2 Date _____ Results _____
 Chest X-Ray (if indicated) Date _____ Results _____
 or
 QuantiFERON-TB-Gold Date _____ Results _____
 or
 T-spot Date _____ Results _____

* Mantoux Tuberculin Skin Test is required annually while in a program that is longer than 1 year.

4. The health physical must be completed within the last six months prior to the start of the class. If completed prior to 6 months a new physical will be required.

I have completed a physical examination for _____ on _____
 and found her/him to be in _____ health. She/he is able to participate in all activities
 and clinical components of the allied health course/program without restrictions.

_____ Phone No. _____
 Print Name (Physician/Nurse Practitioner)

_____ Address

Physician's/Nurse Practitioner's Signature _____

Date _____

If you have any questions regarding this form, please contact BCIT, Adult Education Division,
 at 609-267-4226, ext. 8214 or 8231.

To be completed by BCIT's Official

Reviewed by _____ Date _____
 Program Administrator/Instructor/Staff