**Job Corps Physical Examination Form**

Instructions: This form must be completed by the appropriate Health and Wellness staff and signed off by the appropriate clinician, within 14 days of a student’s arrival to the Job Corps center.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. Ht** | **2. Wt** | **3. BMI** | **4.Waist circum.** | **5.BP** | **6.Heart rate** | **7.Resp rate** | **8.Temp\*** | **9.O2 Sat**  **(%)\*** | **10.Peak flow\*** |
|  |  |  |  |  |  |  |  |  |  |

\*If clinically indicated.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **11. Vision: refer to optometry for any value of 20/40 or J6 or higher** | | | | |
|  | **Distant Vision** | | **Near Vision** | |
|  | **Uncorrected** | **Corrected** | **Uncorrected** | **Corrected** |
| **Right** | 20/ | Corr to 20/ | Jaeger- | Corr to Jaeger- |
| **Left** | 20/ | Corr to 20/ | Jaeger- | Corr to Jaeger- |
| **12. Color vision result (circle one):** | | Pass Fail | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **13. Hearing Screening at 25 decibels: A fail at any HZ requires further evaluation** | | | |
| **HZ** | **1000** | **2000** | **4000** |
| **Right** | Pass Fail | Pass Fail | Pass Fail |
| **Left** | Pass Fail | Pass Fail | Pass Fail |

|  |  |  |  |
| --- | --- | --- | --- |
| **14. Evaluation of the Mouth (check all that apply)** | **Completed by:** | **Date:** | |
| ☐ No obvious oral health findings | ☐ Reports oral pain  Mild Moderate Severe | ☐ Intraoral Swelling ☐ Extraoral Swelling | |
| ☐ Sore in mouth or on lips | ☐ Bleeding in mouth | ☐ Hole in tooth | ☐ Oral Piercing |
| Location of finding: Right Side Left Side Lower Upper Front | | | |
| Other: | | | |

**15. Required Clinical Evaluation.** If clinical examination is unremarkable, check “normal.” If anything is notable, describe the finding in detail. Use extra sheets if necessary. If an area is not examined, include an explanation.

|  | **Normal** | **Describe notable findings or abnormalities** |
| --- | --- | --- |
| 1. **General appearance** |  |  |
| 1. **Ears** |  |  |
| 1. **Eyes** |  |  |
| 1. **Nose and sinuses** |  |  |
| 1. **Mouth and throat** |  |  |
| 1. **Neck (lymph nodes and thyroid)** |  |  |
| 1. **Chest** |  |  |
| 1. **Breasts** |  |  |
| 1. **Lungs** |  |  |
| 1. **Heart (rate, rhythm, sounds)** |  |  |
| 1. **Abdomen and viscera** |  |  |
| 1. **External genitalia** |  |  |
| 1. **Pelvic (if indicated)** |  |  |
| 1. **Anus and rectum (if indicated)** |  |  |
| 1. **Vascular system (pulses)** |  |  |
| 1. **Extremities** |  |  |
| 1. **Spine** |  |  |
| 1. **Skin (include identifying marks, scars, tattoos, piercings)** |  |  |
| 1. **Neurologic** |  |  |
| 1. **Psychiatric/Mental status** |  |  |

**16. Which document(s) have been reviewed?**

☐ Job Corps Health History Form ☐ Immunization records ☐ Laboratory tests

Action or follow-up required:

|  |  |
| --- | --- |
| **17. Acute and/or chronic disease assessment and plan** | |
| **Assessment** | **Plan (e.g., CCMP, medication management)** |
|  |  |
|  |  |
|  |  |

**18. Follow Up Appointment**

☐ Follow-up visit (e.g., # of weeks/months) for (reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **19. Referrals** | |
| **Referred to (Mental health, TEAP, TUPP, HEALs, dentist):** | **Notes** |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **20. Clearance for Participation in Organized Contact for Rigorous Sports** | |
| **Participation in sports (check one)** | **Comments** |
| ☐ Cleared for participation in sports |  |
| ☐ Cleared with the following restrictions |  |
| ☐ Not cleared pending further evaluation |  |
| ☐ Not cleared for participation in sports |  |

Clinician signature: Date:

Nurse signature: Date:

Other health professional signature: Date: