

HEALTH SCIENCES
Physical Examination Form

1. Name: _____

2. Date of Birth: _____

3. Address: _____

4. Phone: (____) - _____ - _____

5. **Step 1 PPD Test**

- Date Administered : _____
- Date Read: _____
- Read by: _____
- RESULT: _____

OR

QuantiFERON TB Gold Test

Results _____

Date _____

Initials _____

**NEW
students
only**

Step 2 PPD Test (administered 7 days after first one is read)

- Date Administered : _____
- Date Read: _____
- Read by: _____
- RESULT: _____

6. Hepatitis B Vaccine #1 _____ #2 _____ #3 _____

7. **ADVANCED PRACTICE CLINICIAN/PHYSICIAN AFFIDAVIT (Must be completed)**

I, as a licensed and registered CLINICIAN, under the laws of the Commonwealth of Pennsylvania, County of _____ have examined _____ and find him/her to be **free of all infectious diseases** with the ability to lift, push, pull, and transfer **a minimum of 50 pounds**.

Provider's Signature

Provider's Printed Name

Provider's Registration Number

Provider's Address

Date: _____

Office Stamp