

Pharmacy Technician Program

Physical Examination Form

To be completed by Health Care Provider (MD, DO, NP, PA, CNM)

Patient Name									
Height	Weight_	Blo	ood Pressure	e,	/	Pulse	Respiratory		
Vision: Uncorr	ected: F	R	L	В		Corrected:	R	L	В
<u>Glasses:</u>	YES	NO	<u>Contacts:</u>		YES	NO			

	Normal	Abnormal with Findings
General Appearance		
Skin		
Head/Ears/Eyes/Nose/Throat		
Neck		
Thorax and Lungs		
Heart		
Spine and Back		
Abdomen		
Extremities/Peripheral Vascular		
Musculoskeletal		
Neurologic		

IMMUNIZATIONS

The following immunizations are required for continuance in the COS Pharmacy Technician Program.

A copy of immunization records and/or lab results is <u>REQUIRED</u> to be included with this Physical Exam Form.

MMR (Measles, Mumps, Rube	2 doses required OR positive immunity titer	
<u>Varicella (Chicken Pox)</u>	2 doses required OR positive immunity titer	
*A note from a doctor/parer	nt stating the student has had the chicken pox <u>will not</u> be accepted	
<u>Hepatitis B Series</u>	3 dose required or postiive immunity Titer	
<u>TB Skin Test</u>	2- step procedure upon intial entry into the PHT program (2nd test should be given 1 -3 weeks after first test)	

*If you are PPD reactor, please attach a copy of chest x-ray results. If chest x-ray is over 12 months, a completed and signed TB Surveillance Form must be included.

Td/Tdap (Tetanus/Diphtheria/Pertussis)

1 dose required

*All adults who have completed a primary series of a tetanus/diphtheria containing product (DTP, DTaP, DT, Td) should receive Td boosters every 10 years.

Flu Vaccine (Seanonal Influenza)

1 dose required Annually



Patient Name_

Physical Examination Form STUDENT ESSENTIAL TECHNICAL STANDARDS

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Pharmacy Technician students must meet the following criteria to ensure the safety and welfare of the patients, the health care team and themselves.

	is the individual capable of the following.				
Yes []	No [] Stand for long periods				
Yes []	No [] Pick and pinch small tablets with fingers, and seize , hold, grasp or turn objects with hands				
Yes []	No [] Perceive the size, shape, temperature, or texture of objects by touching with fingertips.				
Yes []	No [] Lift and push or pull up to 15 pounds.				
Yes[]	No [] see objects at close vision and be able to identify and distinguish colors.				
HEALTH CARE PROVIDER STATEMENT					

Based on your medical evaluation, will this individual be able to carry out the essential technical standards as listed above?

Yes [] No [] If **NO** please explain the reasons and what accommodations may be necessary to assist the individual in participating in the program:

Upon admission, a candidate who discloses a disability and requests accommodation will be asked to provide documentation of his or her disability for the purpose of determining appropriate accommodations, including modification of the program. The College will provide reasonable accommodations, but is not required to make modifications that would substantially alter the nature or requirements of the program or provide auxiliary aids that present an undue burden to the College. To matriculate or continue in the curriculum, the candidate must be able to perform all the essential functions outlined in the Student Essential Technical Standards either with or without accommodations.

I have read t he Student Essential Technical Standards listed for the COS Pharmacy Technician student and verify that this individual is able to meet the physical demands as described above.

Health Care Provider Signature: _____

Date: _____

Print Name: _____

Address: _____

Attach Health Provider Business Card Here

Phone Number: _____