Delgado Community College
School of Allied Health
615 City Park Avenue
New Orleans, LA 70119

Program: Occupational Therapy Assistant
Entrance Date: Fall 2025

HEALTH EXAMINATION FORM

Full and precise information is a requirement for registration.
Each question must be answered. Incomplete records are not accepted.
Print or type all information.

To the student: You are to fill out Part I of this form and have your physician fill out Part II.

PART 1 – MEDICAL HISTORY

Full Name_____

Address_____City/State/Zip_____ Phone_____

Birthdate_____ Marital Status _____Sex_____ Social Security Number_____

Person to be notified in emergency_____ Relationship_____

Address_____City/State/Zip_____Phone_____

Your family physician_____ Office Phone_____

Address_____City/State/Zip_____

History of: ☐Heart disease ☐Hypertension ☐Diabetes ☐Kidney/Disease ☐Emotional Problems
☐Communicable Disease ☐Illnesses ☐Injuries ☐Operations

Specify_____

_____

Are you allergic to any medications, drugs, or foods? (specify)_____

_____

Medicines taken regularly_____

Do you use (yes or no) Alcohol_____ Drugs_____ Tobacco _____

Have you ever been treated for substance abuse? _____ (Explain)_____

Do you have any disabilities? _____(Explain) _____

_____

Additional information _____

_____

_____

Students must have Health or Accident Insurance? Identify insurance company and policy number.

_____

Students are required to have immunization records on file with the Admissions of Delgado Community College.

Students Signature_____Date_____

PART 2 – MEDICAL EXAMINATION (to be completed by physician)

Vital Signs BP_____ P_____ R _____Weight _____ Height_____

Check each item on the appropriate column:

	NORMAL	ABNORMAL	COMMENTS
Head, Face, Scalp, Skin	☐	☐	_____
Neck, Nodes, Thyroid	☐	☐	_____
Eyes, Ears, Nose, Sinuses	☐	☐	_____
Pharynx and Tonsils	☐	☐	_____
Lungs and Chest	☐	☐	_____
Breasts	☐	☐	_____
Heart	☐	☐	_____
Abdomen	☐	☐	_____
Genitalia and Rectum (if indicated)	☐	☐	_____
Extremities	☐	☐	_____
Spine and Musculoskeletal	☐	☐	_____
Neurological	☐	☐	_____
Psychiatric	☐	☐	_____
Communicable Disease	☐	☐	_____

Date of Hepatitis B vaccination: 1_____2_____3_____Tuberculin Skin Test Results_____ Date_____

Positive Titers: Measles _____ Mumps: _____ Rubella: _____ Varicella: _____

If for some medical reason this student is unable to take immunizations, please explain:_____

_____

Has this student any chronic illness?_____ Explain_____

_____

Is this student on any medications (insulin, dilantin, allergy injection, etc?)_____

Give information as to medication name, dosage, etc._____

_____

Is this student cleared to perform the duties of a career in an allied health profession?

_____

SUMMARY OF PHYSICAL EXAMINATION_____

Physician's Name (please print) _____

Address_____Phone_____

Physician's Signature_____Date of Examination_____