

Job Corps Physical Examination Form

	2. Wt¹	3. BMI	4. Waist circum.¹	5. BP	6. Heart rate	7. Resp rate	8. Temp²	9. O₂ Sat (%)²	10. Peak flow²

¹ Height (in), weight (lbs), and waist circumference (in) must also be entered into CIS.

² If clinically indicated.

11. Vision: Refer to optometry for any value of 20/40 or J3 or higher				
	Distant Vision		Near Vision ³	
	Uncorrected	Corrected	Uncorrected	Corrected
Right	20/	Corr to 20/		
Left	20/	Corr to 20/		
12. Color vision (Ishihara) result (circle one):				
		Pass	Fail	

³ Record Jaeger number or distance equivalent.

13. Audiometer⁴									
HZ	250	500	1000	2000	3000	4000	6000	8000	
Right									
Left									

⁴ Record only frequencies tested. Test at 25 decibels. Label with pass (p) or fail (f). If student fails, clinician shall evaluate and determine follow up.

14. Dental Readiness Inspection (circle all that apply) Completed by: _____ **Date:** _____

- | | | |
|------------------------------------|--------------------------|---------------------------------------|
| Hole in tooth | Swelling in mouth or jaw | No obvious serious oral health issues |
| Reported moderate to severe pain | Sore | Bleeding in mouth |
| Affected quadrant (if applicable): | UR UL LL LR | Other: |

Required Clinical Evaluation. Describe every abnormality in detail. Use extra sheets if necessary.

	<i>Normal</i>	<i>Abnormal</i>		<i>Normal</i>	<i>Abnormal</i>	Abnormalities:
15. General appearance			25. Abdomen and viscera			
16. Ears			26. External genitalia (testes and hernia, if male)			
17. Eyes			27. Pelvic (females if indicated)			
18. Nose and sinuses			28. Anus and rectum (if indicated)			
19. Mouth and throat			29. Vascular system (pulses)			
20. Neck (lymph nodes and thyroid)			30. Extremities			
21. Chest			31. Spine			
22. Breasts			32. Skin (include identifying marks, scars, tattoos, piercings)			
23. Lungs			33. Neurologic			
24. Heart (rate, rhythm, sounds)			34. Psychiatric/Mental status			

Student name: _____	Center: _____
DOB: _____	Gender: _____
ID #: _____	Race/ethnicity: _____

35. Immunizations (initial one)

_____ Immunization records reviewed and immunizations required by Job Corps are complete

_____ Immunization records are not yet available

_____ Immunization records reviewed. The following immunizations are needed: _____

36. Laboratory Tests (initial one)

_____ Required laboratory tests/screenings reviewed
_____ Required laboratory test results tests not yet available

Additional laboratory tests/screenings ordered:

37. Acute and/or chronic disease assessment and plan

Assessment	Plan (e.g., Chronic Care Management Plan)

38. Referrals

Referred to (Mental Health, TEAP, TUPP, HEALs, Dentist):	Notes

39. Follow up

Follow-up visit in _____ for _____

Physical exam in (annual for sports participation) _____

40. Clearances

Participation in Job Corps (check one)		Participation in sports (check one)	
<input type="checkbox"/>	Cleared for participation in Job Corps	<input type="checkbox"/>	Cleared for participation in sports
<input type="checkbox"/>	Cleared with the following restrictions:	<input type="checkbox"/>	Cleared with the following restrictions:
<input type="checkbox"/>	Not cleared pending further evaluation	<input type="checkbox"/>	Not cleared pending further evaluation
<input type="checkbox"/>	Not cleared for participation in Job Corps	<input type="checkbox"/>	Not cleared for participation in sports

Clinician signature: _____ Date: _____
 Nurse signature: _____ Date: _____
 Other health professional signature: _____ Date: _____