

## WAGNER PHYSICAL CHECKLIST

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**BRING ALL DOCUMENTATION/PROOF WITH YOU ON DATE OF VISIT!!**  
**BE PREPARED TO SUBMIT A COPY WHEN YOU ARRIVE DO NOT GIVE US ORIGINALS**

MMR, positive titers or proof of vaccination (2 doses)

- I have proof of 2 vaccines given (attach proof) DATES RCVD\_\_\_\_\_
- I have proof of TITERS (attach proof) DATE \_\_\_\_\_ TITER LEVELS\_\_\_\_\_
- I need titers drawn
- I need this Vaccine

Varicella, positive titers or proof of vaccination (2 doses)

- I have proof of vaccination (attach proof) DATE RCVD\_\_\_\_\_
- I have proof of TITERS (attach proof) DATE \_\_\_\_\_ TITER LEVELS\_\_\_\_\_
- I need titers drawn
- I Need this Vaccine

Hep B, positive titers and/or proof of vaccination(3) &amp; Pos Titer

- I have proof of vaccination (attach proof) DATE RCVD\_\_\_\_\_
- I have proof of TITERS (attach proof) DATE \_\_\_\_\_ TITER LEVELS\_\_\_\_\_
- I need titers drawn
- I Need this Vaccine

Dtap/Tdap Vaccine within the last 10 years

- I have proof of this vaccine (attach proof) DATE RCVD\_\_\_\_\_
- I need this vaccine

Meningococcal vaccine - proof of 2 doses before age 18 or booster

- I have proof of this vaccine (attach proof) DATE RCVD\_\_\_\_\_
- I need this vaccine
- I am declining this Vaccine

MenB vaccine

- I have proof of this vaccine (attach proof) DATE RCVD\_\_\_\_\_
- I need this vaccine
- I am declining this Vaccine
- I am above the age of 24

Quantiferon result within past month

- I have proof of this result (attach proof) DATE DONE\_\_\_\_\_
- I need test done

Urine Drug Screen within past month

- I have proof of these results (attach proof) DATE DONE\_\_\_\_\_
- I need test done

Routine blood work ( CBC, CMP, etc...) within past month DATE DONE\_\_\_\_\_

- I have proof of these results (attach proof)
- I need test done

WAGNER PHYSICAL CHECKLIST

I Wear corrective lenses - Yes **OR** No

NEXT PAGE

**PLEASE READ AND SIGN**

MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO HAND IN ALL PROOF REQUESTED ON THE DATE OF THIS VISIT.

I ALSO UNDERSTAND THAT FAILURE TO DO SO WILL CAUSE DELAYS AND MAY RESULT IN NOT HAVING MY PHYSICAL ASSESSMENT FORM COMPLETED BY THE DUE DATE.

MY SIGNATURE BELOW INDICATES THAT I WILL NOT HOLD EG HEALTHCARE OR IT'S STAFF RESPONSIBLE FOR ANY DELAYS CAUSED BY ME. IN ADDITION, IF I AM LATE IN HANDING IN ANY PAPERWORK OR IF I DO NOT SHOW UP TO FOLLOW UP APPOINTMENTS AS NEEDED, I WILL NOT WHINE OR BE RUDE TO THE STAFF AT EG HEALTHCARE, BUT INSTEAD, WILL BE ACCOUNTABLE FOR MY ACTIONS AND ACCEPT ANY DELAYS GRACIOUSLY.

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STUDENT SIGNATURE