MEDICAL EXAMINATION FORM

(INFORMATION CONTAINED HEREIN WILL BE HELD IN CONFIDENCE)

EMS/Nursing Program

Full Name: ___________________________ Exam Date: ____________________
Last 4 of SSN: ________________________ Date of Birth: __________________
Home Address: ____
City: _______________________________ State: ________ Zip: ___________
Home Phone #: ______________________ Cell #: ___________________

All the following information must be provided and/or completed by a health care provider (MD, DO, ARNP, or PA)

Medical History:
Allergies: ____
Current Medications: ____
Surgeries: ____
Major Illnesses: ____
Back/Orthopedic Problems: ____

History of any communicable or infectious disease(s) which may prevent or hinder this applicant's ability to become a member of the healthcare profession. **[ ]NO [ ]YES** (if yes, please explain)
____
____
____

Physical Examination:

Height	Weight	Pulse	Blood Pressure

Vision	Hearing

Positive Findings: ____
____
____
____

PATIENT NAME: ______________________________**DOB:** ______________________

*SHOT RECORDS ARE NOT A SUBSTITUTE FOR TITERS
*NO PHYSICALS OR RECORDS OVER **ONE YEAR** OLD WILL BE ACCEPTED
*TITERS MUST DEMONSTATE IMMUNITY, IF NOT VACCINATIONS/BOOSTERS ARE REQUIRED

Diagnostic Tests/Flu	**Results Date**	**CHECK ONE**	
		Immune	**Not Immune**
Hepatitis B Titer			
Rubella Titer			
Rubeola Titer			
Varicella Titer			
PPD		(negative)	(positive)
Flu Shot (only needed from Sept-Mar)			

(Below are only needed if student does not show immunity to above)

Immunizations	**Date**
Rubella vaccine	
Rubeola vaccine	
Varicella vaccine	
Tdap (only needed if over 10 years)	
*Hepatitis B vaccine *(Hep B vaccine only needed if not immune and has completed series)	
**Chest X-Ray **(Chest X-Ray is required as a follow-up for positive PPD results. After chest X-Ray has been completed)	

Hepatitis B Series: #1_____________ (date) #2______________ (date) #3_____________ (date)
(Hep B series only needed if individual has not started the series or is currently in the series)

Additional Comments/Recommendations:____
____

To the best of my knowledge, this individual is in good physical and mental health.
[ ]NO [ ]YES Date: _______________

_____________________________________/ ____
Signature of Health Care Examiner Name of Health Care Examiner

____
Address City/State/Zip Telephone #

Classes held on campus

Register online WWW.HCI.EDU
or call (561) 586-0121

$50.00 for the REQUIRED BLS COURSE