Continuing Education
Clinical Medical Assistant
Physical Examination Form

TO BE COMPLETED BY STUDENT		
Student Name:	Sex: ❑ M ❑ F	Birth date:
Program Location:		❑ Weekday ❑ Saturday
Have you had a serious illness, injury or surgery?	❑ Yes ❑ No	If yes, please describe:
STUDENT SIGNATURE IS REQUIRED		
I give permission to release a copy of this form to affiliating facility.		
Student Signature:		Date:

TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER

1. Current complaints or disabilities pertinent to the student's participation in training program:

2. Medications used prescription and over-the-counter (use back if necessary):

Name	Indication	Frequency

3. Significant medical history, accidents, deformities, surgeries, back problems, communicable diseases:

4. Examination comments and findings:

The above named has neither communicable nor disabling disease nor health condition that would create a hazard to himself, visitors, classmates or patients at this time. The above named is able to perform the physical activities required for the training.

Examiner Name (please print):	**Phone**:
Examiner Signature:	**Date**:
Address:	

Continuing Education
Clinical Medical Assistant
Physical Examination Form

TO BE COMPLETED BY STUDENT

Student Name: Program Location:

STUDENT SIGNATURE IS REQUIRED

I give permission to release a copy of this form to affiliating facility.

Student Signature: Date:

TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER

Immunization	Documented Dates (attach documentation)		Initials	Comments (attach additional info if needed)
Measles 1st Dose Measles 2nd Dose	Date Date			
Mumps	Date			
Rubella	Date			
Polio	Date			
Influenza	Date			
Varicella	Date			
TD/Tdap	Date			
Tuberculosis Screening (PPD) 90 days prior to the start of class	Date	Results		Date and Result in Millimeters:
Chest X-Ray (if necessary)	Date	Attach results		
Hepatitis B Vaccine	Series 1. 2. 3.			

The above named individual has neither communicable nor disabling disease nor health condition that would create a hazard to himself, visitors, classmates or patients at this time. The above named is able to perform the physical activities required for the training.

Examiner Name (please print): **Phone**:

Examiner Signature: **Date**:

Address: