# Continuing Education
# EKG Technician
## 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<br>Measles 2nd Dose | Date<br>Date | | | |
| Mumps | Date | | | |
| Rubella | Date | | | |
| Polio | Date | | | |
| Influenza | Date | | | |
| Varicella | Date | | | |
| TD/Tdap | Date | | | |
| Tuberculosis Screening (PPD)<br>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<br>1.<br>2.<br>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:**