THIS SIDE TO BE COMPLETED BY THE STUDENT

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Health Science Education

PHYSICAL EXAMINATION REPORT

STUDENT NAME _____
(Please Print) *Last* *First* *Middle*

XXX-XX _____ DATE OF BIRTH _____ SEX ASSIGNED AT BIRTH _____
Last 4 digits of Social Security #

SCHOOL NAME _____
(Please Print)

Admission to the following program (check one)

- ❑ Central Sterile Processing
- ❑ Dental Assisting
- ❑ Dental Lab Technician
- ❑ Electrocardiograph Technology
- ❑ Emergency Medical Technician
- ❑ Hemodialysis Technician
- ❑ Massage Therapy
- ❑ Medical Assisting
- ❑ Medical Coder Biller
- ❑ Mental Health Technician
- ❑ Nursing Assistant
- ❑ Optometric Assisting
- ❑ Orthopedic Technology
- ❑ Patient Care Assistant
- ❑ Patient Care Technician
- ❑ Pharmacy Technician
- ❑ Practical Nursing
- ❑ Surgical Technology
- ❑ Other _____

MEDICAL HISTORY

To be completed by applicant. Please answer ALL questions.

A health report is essential for the above health occupation preparatory programs as evidence that you can meet the demands of the vocation and adjust to these without hazard to self and others in the delivery of patient care. A general routine examination is required with emphasis on information regarding former illnesses, injuries and disabilities. Please complete this page before going to your examination and have the physician review and sign.

Do you have a history of: ***(Please check "Yes" or "No". For "Yes" answers, please use the comment section to explain.)***

Yes	No		Yes	No		Yes	No	
❑	❑	Alcoholism	❑	❑	Chicken Pox	❑	❑	Hearing Problems
❑	❑	Allergy	❑	❑	Convulsions	❑	❑	Hypertension
❑	❑	Arthritis	❑	❑	Diabetes	❑	❑	Jaundice/Hepatitis
❑	❑	Asthma	❑	❑	Drug Dependency	❑	❑	Mental Illness
❑	❑	Auto Immune Disorder	❑	❑	Epilepsy	❑	❑	Persistent Cough
❑	❑	Back/Joint Problems	❑	❑	Fainting	❑	❑	Vision Problems

Comments: _____

_____

_____

Do you have any restriction of movement? ❑ **Yes** ❑ **No**
If "Yes" describe: _____

_____

_____

Have you ever had a back ailment? ❑ **Yes** ❑ **No**
If "Yes" describe: _____

_____

_____

THIS SIDE TO BE COMPLETED BY A HEALTH CARE PRACTITIONER

***HEALTH CARE PRACTITIONER:** Please review the student's history, complete and sign the Health Care Practitioner's section of the Physical Examination Report. Please comment on all positive answers*

STUDENT NAME _____ XXX-XX _____
(Please Print) Last First Middle Last 4 digits of Social Security #

Height:	*Weight:*	*Blood Pressure*	
Vision Test			
Right Eye:	*Left Eye:*	*Corrected Right Eye:*	*Corrected Left Eye:*

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING AREAS:

Yes	No		Comments
❑	❑	Skin	_____
❑	❑	Head, Ears, Nose, Throat	_____
❑	❑	Eyes	_____
❑	❑	Respiratory	_____
❑	❑	Cardiovascular	_____
❑	❑	Gastrointestinal	_____
❑	❑	Hernia	_____
❑	❑	Genitourinary	_____
❑	❑	Musculoskeletal	_____
❑	❑	Endocrine	_____
❑	❑	Neuropsychiatric	_____

Is there impaired function of any organ? _____

Is the applicant under treatment for any medical or emotional condition? _____

Comments: _____

_____

_____

Is this applicant physically and emotionally qualified to participate in all classroom and clinical activities of a health occupations program? ❑ Yes ❑ No

If "No" give reason: _____

_____

_____

I understand that clinical affiliates may require copies of my medical records. I hereby certify the above statements are true and that any misrepresentation of fact may be grounds for withdrawal from the program.

_____	_____	_____
Student Signature	**Parent Signature (*if student is under 18*)**	**Date**
_____	_____	_____
Health Care Practitioner's Signature	**Provider's License Number**	**Date**