THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
Health Science Education

PHYSICAL EXAMINATION REPORT

NAME ____ XXX-XX-__________________
(PRINT) Last First Middle Last 4 digits of Social Security #

Check One:

______ Atlantic Technical College 754-321-5100
______ ATC, Arthur Ashe, Jr. Campus 754-322-2800
______ Blanche Ely High School 754-322-1015
_______ McFatter Technical College 754-321-5700
_______ Sheridan Technical College 754-321-5400
_______ STC, West Campus 754-321-3900

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 Technician
_______ Pharmacy Technician
_______ Practical Nursing
_______ Surgical Technology
_______ Other______________________

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.

MEDICAL HISTORY: To be completed by applicant. Please answer all questions.
For "Yes" answers, please use the comment section to explain.

Do you have a history of: (Please check "Yes" or "No")

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: ____

TO THE EXAMINING PRACTIONER: Please review the student's history, complete and sign the Health Care Practioner's section of the Physical Examination Report. Please comment on all positive answers.

HEIGHT:	WEIGHT:	BLOOD PRESSURE:	
VISION: RIGHT EYE:	LEFT EYE:	CORRECTED: RIGHT EYE	LEFT EYE

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING AREAS:

	YES	NO	COMMENTS
1. Skin	____	____	____________________
2. Head, Ears, Nose, Throat	____	____	____________________
3. Eyes	____	____	____________________
4. Respiratory	____	____	____________________
5. Cardiovascular	____	____	____________________
6. Gastrointestinal	____	____	____________________
7. Hernia	____	____	____________________
8. Genitourinary	____	____	____________________
9. Musculoskeletal	____	____	____________________
10. Endocrine	____	____	____________________
11. Neuropsychiatric	____	____	____________________
Is there impaired function of any organ?	____	____	____________________
Is the applicant under treatment for any medical or emotional condition?	____	____	____________________

Any general 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.

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____

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 ______________ Date

______________________________ Health Care Practitioner's Signature ______________________________ Provider's License Number ______________ Date

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