

**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

Last 4 digits of Social Security #

DATE OF BIRTH \_\_\_\_\_

SEX ASSIGNED AT BIRTH \_\_\_\_\_

SCHOOL NAME \_\_\_\_\_

(Please Print)

Admission to the following program (check one)

☐ Central Sterile Processing

☐ Massage Therapy

☐ Orthopedic Technology

☐ Dental Assisting

☐ Medical Assisting

☐ Patient Care Assistant

☐ Dental Lab Technician

☐ Medical Coder Biller

☐ Patient Care Technician

☐ Electrocardiograph Technology

☐ Mental Health Technician

☐ Pharmacy Technician

☐ Emergency Medical Technician

☐ Nursing Assistant

☐ Practical Nursing

☐ Hemodialysis Technician

☐ Optometric Assisting

☐ 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

☐ ☐ Alcoholism

☐ ☐ Allergy

☐ ☐ Arthritis

☐ ☐ Asthma

☐ ☐ Auto Immune Disorder

☐ ☐ Back/Joint Problems

Yes No

☐ ☐ Chicken Pox

☐ ☐ Convulsions

☐ ☐ Diabetes

☐ ☐ Drug Dependency

☐ ☐ Epilepsy

☐ ☐ Fainting

Yes No

☐ ☐ Hearing Problems

☐ ☐ Hypertension

☐ ☐ Jaundice/Hepatitis

☐ ☐ Mental Illness

☐ ☐ Persistent Cough

☐ ☐ 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
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Head, Ears, Nose, Throat
<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal
<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine
<input type="checkbox"/>	<input type="checkbox"/>	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



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