PHYSICAL EXAMINATION FORM

To be completed by the Health Care Provider.

This information is solely for the use of the College and will not be released without the student's consent.

STUDENT'S NAME: ________________________________ **DATE OF BIRTH:** ____________________

(Last) *(First)* *(MI)*

VISION: RIGHT 20/___ LEFT 20/___

COLOR VISION: ADEQUATE: _______ NOT ADEQUATE: _______

HEARING: ADEQUATE: _______ NOT ADEQUATE: _______

BLOOD PRESSURE: ________/________

CHECK ANY IRREGULARITIES OF THE FOLLOWING:

___ EYES, EARS, NOSE, THROAT
___ RESPIRATORY
___ TEETH
___ SKIN
___ GASTROINTESTINAL
___ HERNIA
___ CARDIOVASCULAR
___ MUSCULOSKELETAL
___ METABOLIC/ENDOCRINE
___ GENITOURINARY

HAS THE STUDENT RECEIVED OR IS THE STUDENT UNDER TREATMENT FOR ANY PHYSICAL, NEUROLOGICAL, OR EMOTIONAL PROBLEMS? **YES** ________ **NO** ________

ESTIMATE OF STUDENT'S HEALTH STATUS

EXCELLENT ________ GOOD ________ FAIR ________ POOR ________

IN YOUR JUDGEMENT, DO YOU BELIEVE THAT THIS STUDENT IS CAPABLE OF MASTERING THE PHYSICAL, EMOTIONAL, ATTITUDINAL, AND COGNITIVE TASKS REQUIRED OF A STUDENT ENROLLED IN A CLINICAL MEDICAL ASSISTING OR PHLEBOTOMY PROGRAM. **YES** ________ **NO** ________

REMARKS OR ADDITIONAL INFORMATION: ____

____

____

____

NAME OF HEALTH CARE PROVIDER:
(PLEASE PRINT AND SPECIFY MD, PA, NP) ____

SIGNATURE: ____

ADDRESS: ____

____

TELEPHONE: ____________________ **DATE:** ____________________

CASTLE BRANCH FORM

(To be completed by the Allied Health Program Manager)

After a review of the Roxbury Community College Physical Examination Form:

STUDENT'S NAME: ______________________________ **DATE OF BIRTH:** ____________________

(Last) (First) (MI)

Received a satisfactory physical examination on: Date: __________

Received an unsatisfactory physical examination on: Date: __________

Name of Health Care Provider (MD, PA, NP): ______________________________

Address: ______________________________

Telephone: ______________________________

Name of Allied Health Program Manager:
(Reviewer of this form) ______________________________

Signature: ______________________________

Date: ______________________________