RC Health Services
Emergency Medical Services Training
Physical Examination Form

Student Name: ____
Last First Middle

SSN:	D.O.B:	Age:

Home Address: ____

City:	State:	Zip:

Home Number:	Work Number:

Past Medical History:
____
____
____
____
____

Height:	Weight:

Eyes: Vision R ________ L ________	Corrected: R ________ L ________

Physical Exam	**Positive Finding**	**Negative Finding**
Ears:		
Sinuses:		
Teeth:		
Thyroid:		
Skin:		
Abdomen:		
Heart:		
Lungs:		
Blood Pressure:		
Back:		
Orthopedic Condition:		
Extremities:		

Test/Vaccination	Date	Outcome
Tuberculosis	______________________________	
Hepatitis B, first vaccine must be given before clinical rotations can begin or positive Titer test	# 1: ___________________________ # 2: ___________________________ # 3: ___________________________	
Measles, Mumps, Rubella or Positive Titer test	# 1: ___________________________ # 2: ___________________________	
Varicella or Positive Titer test	# 1: ___________________________ # 2: ___________________________	
Diphtheria and Tetanus (TD), within 10 years	______________________________	

Physician Name:	Physician Signature:
____	____

Physician Address:			
City: ______________________	State: ______________________	Zip Code: ______________________	Phone Number: ______________________

Please return this form to the Clinical Coordinator's office, on or before Clinical Orientation Day.