ATLANTIC CAPE COMMUNITY COLLEGE | HEALTH PROFESSIONS INSTITUTE

HEALTH REPORT FORM

The following information is required before registration. Please bring this form with you to your primary care provider to insure that you meet all requirements. Please Print.

Student Name: _____Phone#: _____

Address:_____

Check Program: ____ CNA ____ EMT ____Medical Assistant ____ Phlebotomy Technician ____ Paramedic ____ Patient Care Technician _____EKG _____Central Service Technician

	Date	Results
Physical Exam		
TDAP		
Measles/Mumps/Rubella		
Hepatitis B **(3 series dates or titers date)**		
Tuberculin Skin Test		
Chest X-ray (if positive reactor)		
Five (5) Panel Urine Drug Screening		
Tetanus Booster within 10 Years		

The physical exam, PPD/skin test and drug screening must be performed within 3 months of first date of class. Additional PPD may be required prior to clinical module.

If Female: Are you currently pregnant? ____no ____yes. If yes, due date: _____
Comments:

Do you feel the student can fulfill the obligations of the program chosen? _____

Physician's Signature: _____ Date: _____

Print Physician's Name and Address:_____

_____

Revised 8/9/18
Health Report Form/Physician Report Form are used for all programs. Any questions, please contact Program Navigator, 609-343-5655 or mmatulev@atlantic.edu