PHYSICIAN 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. ***Must be performed within 3 months of first day of class.***

Please Print
Student Name: ____Phone#: _________________________

Address: ____

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

Height: __________ Weight: __________ Blood Pressure: _____________________ Pulse: _______________

Heart: Is there any:

Enlargement	Yes ____	No ____	Dyspnea	Yes ____	No ____
Murmur	Yes ____	No ____	Edema	Yes ____	No ____

Is there on examination any abnormality of the following?

1. Eyes, ears, nose, mouth, pharynx? Yes ____ No ____
2. Skin; lymph nodes; varicose veins or peripheral arteries? Yes ____ No ____
3. Nervous system, including reflexes, gait? Yes ____ No ____
4. Respiratory system? Yes ____ No ____
5. Abdomen, including scars? Yes ____ No ____
6. Genitourinary system, including prostate? Yes ____ No ____
7. Endocrine system? Yes ____ No ____
8. Musculoskeletal system? Yes ____ No ____
9. Are there any hernias? Yes ____ No ____
10. Are there any hemorrhoids? Yes ____ No ____
11. Are you aware of additional medical history or physical limitations that would prevent this patient from performing the duties of a **program above?** Yes ____ No ____

Please describe below any "yes" response. Designate the # from above.

Physician's Signature: ____ Date: _______________

Print Physician's Name and Address: ____

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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