

EMT Program _____
Paramedic Program _____

CENTRAL TEXAS COLLEGE
Department of Nursing and Allied Health

PHYSICAL EXAMINATION FORM
(To be filled out by applicant)

IDENTIFYING INFORMATION:

Name: _____ Program Enrollment Date: _____

Home Address: _____ Telephone: _____

List your medical history with dates if known. Include chronic illness, surgical procedures, and mental health history.

ALLERGIES/Reactions to medications: _____

List medications you are presently taking:

List all medications that you are currently taking to include prescription and OTC	Dosage/Frequency	Indication

The above completed medical history form is current, complete and accurate to the best of my knowledge and is a true description of my current health status.

Family Physician: _____
Printed/Typed NAME ADDRESS TELEPHONE

Printed/Typed Name of Student: _____

Signature of Student _____ Date _____

**PHYSICAL EXAMINATION FORM
(To be filled out by Health Care Provider)**

NAME: _____ SEX _____ WEIGHT _____ HEIGHT _____

Check each item in appropriate column	Normal	If Abnormal or with limitation, please detail. Attach a sheet if necessary
Eyes		
Vision: Uncorrected		
Corrected	R 20/ L 20/	
Color Vision	R 20/ L 20/	
Ears/Hearing		
Nose/Throat		
Mouth, Teeth		
Thyroid		
Vascular		
Lungs		
Heart		
Neck & Vertebrae		
Extremities; Range of Motion		
Hand/Eye Coordination		
Fine Motor Dexterity		
Neurological/Reflexes		
Skin		
Abdomen		
Kidneys & Bladder		
Other		

REQUIRED FOR ADMISSION: 1) 2 doses of measles vaccine administered on or after 1st birthday at least 30 days apart for all students born on or after 1/1/57; 2) 1 dose of mumps vaccine administered after 1st birthday for all students born on or after 1/1/57; 3) 1 dose of rubella vaccine after 1st birthday; 4) Hepatitis B series (3 doses of vaccine over 6 month period); 5) 2 doses of the Varicella (Chicken Pox) vaccine or documentation of having had the disease; 6) Tdap once in lifetime, followed by TD every 10 years; 7) Bacterial Meningitis for any student under 22 years of age. A positive titer showing immunity will be accepted in lieu of vaccines; 8) TB skin test or CXR; 9) Annual flu vaccine.

Please answer the following:

- Yes: ____ No: ____ Based upon your physical examination, is the applicant free of any restrictions in his/her ability to turn, move, transfer, or manipulate objects up to 30 lbs, and able to safely perform physically taxing tasks? If no, please describe:
- Yes: ____ No: ____ Does the applicant possess adequate visual and auditory acuity to practice as a health care professional? If no, please describe:
- Yes: ____ No: ____ Is the applicant free of conditions either physical, mental, or behavioral that would interfere with the practice of a health professional or effective communication? If no, please describe:

Additional Comments: _____

Classification for Physical Activities: (Circle): ****For EMT/Paramedic Students— They must have the ability to lift, carry, and balance up to 125 pounds (250 pounds with assistance); ability to work effectively in an environment with loud noises and flashing lights. Good manual dexterity, ability to bend, stoop and crawl on uneven terrain, withstand varied environmental conditions such as extreme heat, cold, and moisture.**

- A. Unlimited
 B. Limited (Explain If Limited): _____

Printed Name of M.D./D.O./Nurse Practitioner/Physician Assistant:

Signature of M.D./D.O./Nurse Practitioner/Physician Assistant:

If Physician Assistant PRINT name of supervising M.D.: _____

Date of Physical Exam: _____

Address: _____

Phone #: _____