EMERGENCY MEDICAL SCIENCES PROGRAM
STUDENT PHYSICAL EXAM FORM

NAME: _____ SEX: __ M __ F D.O.B: ____/____/____ AGE: _____

SSN: _____ ID# _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Other: _____

MEDICAL HISTORY

Do you suffer from or are you being treated for any of the following Health conditions?

	YES	NO
A. Head injuries, seizures, unconsciousness, Concussion/convulsion	_	_
B. Neck or Back Injury	_	_
C. Contact Lenses/Glasses	_	_
D. Asthma	_	_
E. Tuberculosis	_	_
F. Heart Disease	_	_
G. Rheumatic Fever	_	_
H. High Blood Pressure	_	_
I. Eye, Lung, or Kidney removed or non-functioning.	_	_
J. Hepatitis	_	_
K. Sickle Cell Anemia	_	_
L. Cancer/Blood Disorders	_	_
M. Hernia	_	_
N. Skin Disease	_	_
O. Bone or Joint Disease or injury	_	_
P. Emotional or Psychological Disturbances	_	_
Q. Diabetes	_	_
R. Surgeries (operations)	_	_
S. Drugs or Alcohol	_	_

Explain any Yes Answers: _____

PHYSICAL

Allergies: _____

Medications: _____

Height: _____ Weight: _____

Vital Signs:

Temp: _____ P: _____ R: _____ BP:_____

Eye: _____ Ear: _____ Nose: _____ Teeth:_____

Throat: _____ Lung: _____ Heart: _____

Abdomen: _____ Hernia: _____ Skin: _____

Posture: _____ Reflexes: _____

Remarks and Recommendations:_____

I certify that I have examined this individual and find that he/she is physically suitable/unsuitable for the Emergency Medical Technology Program as stated by the DSHS Essentials of Eligibility.

Remarks: _____

_____

Printed or Typed Name of Physician or Nurse Practioner

Date of Exam

Signature of Physician or Nurse Practioner

Address and Phone Number

Immunizations: **Td:** _____ **Hepatitis B: 1st :** _____ **2nd:** _____ **3rd:** _____

TB: (PPD) _____ **__Negative __Positive (If positive, list further testing)** _____

Hepatitis A: 1st _____ **2nd** _____