GEORGIA TRAINING CENTER PHYSICAL EXAMINATION FORM

*To be completed and **signed** by a physician, PA, or nurse practitioner. All sections required. Please print in black or blue ink.*

TO BE COMPLETED BY THE STUDENT:

			Medical Assistant Program
Last Name	First Name	Middle Name	

Date of Birth (mo/day/year)	Major	Area Code/Phone Number

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

Height ___________ Weight___________ BP ___________/__________

Vision Screening

Corrected: Right 20/ ______Left 20/ ______

Uncorrected: Right 20/______Left 20/ ______

Color Vision:☐ Normal ☐ Abnormal *(please explain)*

____

Hearing Screening

Gross/Overall Hearing:
☐ Normal ☐ Abnormal *(please explain)*

____

____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? ☐Yes☐No
Explain ____

B. Is student under treatment for any medical or emotional condition?☐ Yes ☐ No
Explain ____

C. Recommendation for physical activity (physical education, intramurals, etc.) ☐Unlimited ☐Limited
Explain ____

D. Is student physically and emotionally healthy?☐ Yes ☐ No
Explain ____

E. **Based on my assessment of this student's physical and emotional health, he/she appears able to participate in the <u>activities of a health profession in a clinical setting</u>**. ☐ Yes ☐No If no, please explain.

Explain: ____

<u>CERTIFICATION REQUIRED:</u>

____
Signature & Credentials of Physician/Physician Assistant/Nurse Practitioner **Date**

____
PRINT Name & Credentials of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

____
Name of Practice/Agency

____
Office Address **City/State** **Zip Code**