Date rec'd by EMS Education: ___________

Emergency Medical Technician Student Physical Examination Report

Grant Medical Center
EMS Education

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Columbus OH 43215-4741
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State of Ohio Accreditation No. 314

Name ______________________ Date ___________

Age ___________ Height ___________ Weight ___________

Vision:

Left Eye ___________ Right Eye ___________ Both Eyes ___________

Any corrective lenses? Yes No

History and Physical Examination:

Heart ______________________

Lungs/Chest ______________________

Head ______________________

Ears ______________________

Nose ______________________

Throat/Neck ______________________

Abdomen ______________________

Back ______________________

Extremities ______________________

History of Any Chronic Illness? ______________________

Any Physical Limitations? ______________________

List All Regular Medications? ______________________

Has student had:

Measles ___________
Mumps ___________
Rubella ___________
Chicken Pox ___________
NOTICE: Varicella Titre IgG- (Proof of Immunity) is Required; Attach lab report

Immunization dates:

Polio ___________
Measles ___________
Mumps ___________
Rubella ___________
HbV #1 ___________
HbV #2 ___________
HbV #3 ___________
TB (PPD) ___________
NOTICE: TB (PPD) is Required Annually; Must be current during school

______________________ ______________________ ___________
Physician Name (Printed or Typed) Physician Signature Date