Montgomery County Community College
PHYSICAL EXAMINATION FORM
340 DeKalb Pike, Blue Bell, PA 19422
www.mc3.edu

CONFIDENTIAL

Patient's Name: _____ **Date of Birth:** _____

MAJOR: (check one) ☐Dental Hygiene ☐Medical Assisting ☐Medical Laboratory Technician ☐Nursing

☐Phlebotomy ☐Radiography ☐Surgical Technology ☐Physical Therapist Assistant

To be completed by Health Care Provider**:** Please review the patient's history, complete this form and comment as indicated.

BP:	Height:	Weight:
Temperature:	Pulse:	Respirations:

Vision Screening	WNL	Remarks:
Hearing Screening	WNL	Remarks:
Nose	WNL	Remarks:
Throat	WNL	Remarks:
Neck	WNL	Remarks:
Lungs	WNL	Remarks:
Heart	WNL	Remarks:
Abdomen	WNL	Remarks:
Lymph Glands	WNL	Remarks:
G.U.	WNL	Remarks:
Skin	WNL	Remarks:
Neuro	WNL	Remarks:
Musculoskeletal	WNL	Remarks:

Current medical problems: _____

Summary of significant findings in history and physical exam: _____

Current medications: _____

Allergies:_____

URINE DRUG SCREEN (If your program is using CastleBranch, you must order your drug screen through CastleBranch and go to their assigned laboratory for testing.) **Attach copy of laboratory report for ALL of the following substances**:

1. Amphetamines
2. Benzodiazepines
3. M-AMP (Methamphetamine)
4. Oxycodone
5. Methadone
6. Barbiturates
7. Cocaine
8. Opiates
9. PCP
10. THC (marijuana metabolites)

Is the applicant free from any cognitive/mental and/or physical restrictions that would limit ability to undertake the specific Health Program?

Yes ____ No ____ If **NO,** please describe in detail: _____

_____

_____

Is this patient medically qualified to participate in the specific health program? Yes ____ No ____

This student has a history of: Addiction ____ Depression ____ Anxiety ____ Eating disorder ____ ADHD ____ None of these ____

Is this student under care for a chronic condition or serious illness? Yes ____ No ____ If **YES,** please explain: _____

_____

_____

Clinician's Signature: _____ Date Exam Was Completed: _____

Clinician's Printed Name: _____ Clinician's Address: _____

Clinician's Phone #: _____ Clinician's Fax # _____