Goodwin College
Department of Health and Natural Sciences
One Riverside Drive
East Hartford, Connecticut 06118

Physical Examination for Medical Assisting Students

Name   Date of Birth

I, the above listed student, hereby give permission for this document to be released to Goodwin College. Furthermore, I give permission to share this document with the clinical sites to which I am assigned, upon request by the clinical site.

Student Signature

To Be Completed by Physician/Physician Assistant or Nurse Practitioner:
Physical Exam (must be within past 2 years)
Date Completed
Any physical, mental, emotional, or other limitations that would restrict clinical participation?
Yes ______ No ______
If yes, please explain. ____
____

If Available, Please Attach a Copy of Immunization Record or Lab Results
PPD/Mantoux (must be within past 12 months and updated annually)
Test Result: _______ Date Read: ______
*If PPD is positive, a chest x-ray must be taken
X-Ray Result: _________Date Read: ______

Varicella
Date of Infection/Vaccination   Titer Result: Titer Date

Tetanus
Date of last tetanus ______________
If date of last tetanus is over 7 years old or unknown, a booster is needed

History of Hepatitis B Vaccination or Immunity
Positive Titer Date

OR

Dose #1 Date Dose____________________
#2 Date Dose #3
Date

Physician's Name ____(please print)
Physician's Signature _____________________________________
Address ____Telephone ________

If there are any questions, please call Danielle Wilken @ 860.727.6780