Harborview School of Phlebotomy, LLC
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West Haven, CT 06516
(475) 238-6678 Fax (475) 238-7950

Medical Education Student Physical Examination Form

Student Full Name: _____ Student Phone: _____

Last 4 Digits of Social Security #: _____ Date of Birth: _____

TO THE EXAMINATING HEALTH CARE PROVIDER:
Each student participating in a Phlebotomy Technician Training program is required to successfully pass a complete physical examination and be certified as physically able to participate by a healthcare provider (MD, DO, Nurse practitioner, Physician's assistant). The Harborview School of Phlebotomy wants to protect the physical wellbeing of every student. The objective takes precedence over personal interest or activity needs. Please evaluate whether the student has any health issues that would interfere with their ability to meet the guidelines listed on the reverse side of this form. Students who fail to meet these guidelines should be advised to refrain from participating until health issues are corrected.

Height: _____ Weight: _____ T _____ P _____ R _____ BP _____

Allergies: Asthma _____ Eczema _____ Other _____

Head: Frequent Headaches _____ Dizziness _____ Other _____

Cardio-Respiratory: Chronic cough _____ SOB _____ HTN _____ Other _____

Endocrine: Diabetes _____ Hypoglycemia _____ Other _____

Bones and Joints: Arthritis _____ Fractures _____ Sprains _____ Other _____

Back pain / Previous Injuries _____

Lower Extremities: Swelling _____ Foot Trouble _____ Varicose Veins _____ Other _____

Neurological: Epilepsy _____ Convulsions _____ Other _____

Pregnancy: Current Status _____

Frequency of Alcohol / Drug / Tobacco use: _____

Current medication: _____

Any serious medical illness/ Injury/surgery in past year _____

Current medical or surgical condition: _____

Hearing Impairments: _____

Visual Impairments: _____

HEATHCARE PROVIDER'S SIGNATURE REQUIRED ON BACK

8/2016

PHYSICAL GUIDELINES FOR MEDICAL EDUCATION STUDENTS

1. **Strength**: Students must be able to perform physical activities requiring ability to push/pull objects more than 50 pounds and to transfer objects of more than 100 pounds (with assistance)
2. **Manual Dexterity**: students must be able to perform motor skills such as standing, walking and handshaking, and manipulative skills such as writing and calibration of equipment.
3. **Coordination**: Students must be able to maintain body coordination such as walking, retrieving equipment, hand pressure, coordination such as keyboard skills, and task which require arm-hand steadiness such as drawing blood, taking blood pressure, calibration of tools and equipment, etc.
4. **Mobility:** Students must be able to perform mobility skills such as walking, standing, and occasionally prolonged standing or sitting in an uncomfortable position.
5. **Tactile:** Students must have tactile ability sufficient for physical assessment. Must be able to perform palpation, function of physical examination and/or those related to therapeutic intervention.
6. **Conceptualization:** Students must be able to understand and relate to specific ideas, concepts and theories generated and simultaneously discussed.
7. **Memory:** Students must be able to remember task/assignments given to self and others over both long and short periods of time.
8. **Critical Thinking:** Students must possess critical thinking ability sufficient for clinical judgement. Must be able to apply theoretical concepts to clinical settings.
9. **Interpersonal**: Students must have interpersonal skills sufficient to interact with individuals, families and groups from a variety of social, emotional, cultural and intellectual backgrounds.
10. **Communication**: Students must be able to communicate effectively during interaction with others in written and verbal form. Must be able to explain treatment procedures and initiate health teaching.
11. **Substance Abuse**: Students must display no evidence or indication of current alcohol or drug abuse.

If student is pregnant, OB/GYN healthcare provider signature is required for enrollment due to lifting requirement as listed in guidelines.

<u>After reviewing the patient's medical history and reviewing program guidelines (Please check one)</u>

_____ I hereby certify this patient is physically able to fully participate in this program.

_____ I an not able to approve this patient for full participation in this program.

_____ _____

Name (print) of examining healthcare provider Title of examining healthcare provider

_____ _____

Signature of examining healthcare provider Date of Examination