

Miami Technical Institute School Physical Health Exam Form

Date: _____

Name: _____

Date of Birth: _____ Social Security Number: _____

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Temp: _____

Eyes: _____ Nose: _____ Ears: _____ Throat: _____

Teeth: _____ Neck: _____ Shoulders: _____ Back: _____

Legs: _____ Wrists: _____ Fingers: _____ Breasts: _____

Hernia: _____ Heart: _____ Skin: _____ Allergies: _____

Summary: _____

Immunizations:

Measles _____ Mumps _____ Rubella _____ Varicella _____

Tuberculin skin test (PPD) _____

Influenza Shot (FLU) _____

This document is to be filled out and signed by a physician only.

In my opinion, _____ is physically and mentally able to perform duties in Healthcare.

Print Doctor Name

Office Stamp

Doctor Signature