

**DURHAM TECHNICAL COMMUNITY COLLEGE
HEALTH AND WELLNESS DEPARTMENT**

The Student Medical Form is required by clinical agencies for students to be able to participate in clinical experiences. Each program will indicate to students when these forms are to be completed. It is expected that the student will submit an honest and accurate record. Omissions, whether intentional or not, are in violation of the College's Academic Honesty policy. Any student found in violation of this policy will not be permitted to participate in clinical and may be dismissed from the C 52>401oaW,389)-200(-5004140-8h02>3630 q05 (g)0r-30)9)-4



Office Address
OFFICE STAMP:

City/State/Zip Code

PHYSICAL EXAMINATION (To be completed and signed by physician, PA or NP.) Please print in black ink.

Last Name	First Name	Middle/Maiden Name	Date of Birth
Address	City/State/Zip Code		Area Code/Phone Number

Height _____	Weight _____	TPR _____ / _____ / _____	BP _____
Vision: Corrected Right 20 _____ Left 20 _____ Uncorrected Right 20 _____ Left 20 _____	Hearing: (gross) Right _____ Left _____ 5 ft. Right _____ Left _____		
Color Vision			
Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1 Head, Ears, Nose, Throat			
2. Eyes			
3 Respiratory			
4 Cardiovascular			
5. Gastrointestinal			
6 Hernia			
7 Genitourinary			
8 Musculoskeletal			

