Program Director / Clinical Coor. Surgical Technology Prog.

NORTH FLORIDA INSTITUTE
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PHYSICAL EVALUATION FORM

~~Student~~ Name: Heather L. Dawson Date: 11/20/08

Address: 3536 Marsh Cove Drive

City: Jacksonville State: FL Zip: 32224

Is there any history of the following:

Vision Problems	Yes ☐	No ☑
Hearing Problems	Yes ☐	No ☑
Dizziness or Fainting	Yes ☐	No ☑
Asthma	Yes ☐	No ☑
High Blood Pressure	Yes ☐	No ☑
Diabetes	Yes ☐	No ☑
Epilepsy or Seizures	Yes ☐	No ☑
Other	Yes ☐	No ☐

If answer to any of the above is yes, please explain:

Is the patient currently pregnant? No

EDC:

Are there any allergies? NKDA

Is this student able to work with and around people?
Yes ☑ No ☐

Are there any significant emotional problems?
Yes ☐ No ☑

Does the student have normal manual dexterity?
Yes ☑ No ☐

Would you consider this person employable in the medical profession?
Yes ☑ No ☐

Any current medications?
TRISPRINTEC

Any history of infectious disease?

TB Test Date
Results: **Positive ☐ Negative ☐**

Date test was read

Physicians Signature
Physician to sign only when TB test is read

*In cases where the student is pregnant, the doctor must fill out a release form.

Hepatitis #1
Hepatitis #2
Hepatitis #3

Varicella
(For Surgical Tech & Pharm Tech students only)
MMR 12-7-80 11-4-02
(For Surgical Tech & Pharm Tech students only)

I understand that this examination is not intended to replace a full and complete physical examination, and is designed only for screening purposes, to ensure that I do not carry any communicable diseases and am physically capable of performing the duties required by the curriculum. I agree to third party release of information concerning my test results.

Student's Signature Physician's Signature:

Address: 14546 St. Augustine Rd Ste 311

City / State /Zip: Jax FL 32258

Eff. 9/7/06