Belmont College Medical Assisting & Phlebotomy Programs

Name _____ Address _____

City _____ State _____ Zip Code _____ Phone # _____

Belmont College Email: _____ Age: _____

In case of emergency, Contact _____ Relationship _____Phone Number _____

Throughout my time in the program, I hereby authorize the program and faculty to release my name and email address, history and physical and immunization, drug testing records and state and federal background check information to any clinical site(s) where I am assigned; release my name and email address to any educational vendor(s) which are utilized as instructional methods by the program; and to access my individual scores and performances in any electronic instructional methods.

Student Signature: _____

Witness to Student Signature: _____ Date: _____

Physical Exam: Completed by Practitioner (MD, DO, NP, PA)

Ht. _____ Wt. _____

Check and record <u>ONLY</u> <u>ABNORMALITIES</u> of the following:

☐Neurological	☐Musculoskeletal	☐Psychological	☐Skin
☐EENT	☐Reproductive	☐Cardiovascular	☐Current Pregnancy Status
☐Pulmonary	☐Allergies	☐GI/GU	

Further explanation of any noted abnormalities:

Significant findings and/or limitations:

Significant Past Medical/Surgical History:

Current Routine & PRN Medications:

To the best of my judgment/knowledge, _____ is physically and emotionally able to undertake the Medical Assisting or Phlebotomy Technician program at Belmont College without restrictions.

_____ _____

Healthcare Provider's Signature **Date of Exam**

_____

Office Phone Number

Completed within 12 months of entering the program.