Date rec'd by EMS Education: _____

Paramedic Student
Physical Examination Report

Grant Medical Center
EMS Education

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393 East Town Street
Columbus OH 43215-4741
(614) 566- 8289
fax (614) 566- 8359

info@grantemseducation.com
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State of Ohio Accreditation No. 314

Name _____ Date _____

Age _____ Height _____ Weight _____

Vision:

Left Eye _____ Right Eye _____ Both Eyes _____

Any corrective lenses? Yes No

History and Physical Examination:

Heart _____

Lungs/Chest _____

Head _____

Ears _____

Nose _____

Throat/Neck _____

Abdomen _____

Back _____

Extremities _____

History of Any Chronic Illness? _____

Any Physical Limitations? _____

List All Regular Medications? _____

Has student had:

Measles _____
Mumps _____
Rubella _____
Chicken Pox _____
NOTICE: Varicella Titre IgG- (Proof of Immunity) is Required, Attach lab report

Immunization dates:

Polio _____
Measles _____
Mumps _____
Rubella _____
HbV #1 _____
HbV #2 _____
HbV #3 _____
TB (PPD) _____
NOTICE: TB (PPD) is Required Annually, Must be current during school

Physician Name (Printed or Typed) _____ Physician Signature _____ Date _____