

MEDICAL EXAMINATION REPORT
Hillside Health Center
333 Laws Avenue
707-468-1010

STUDENT COMPLETES THIS SECTION																																																																										
NAME			SOCIAL SECURITY NUMBER																																																																							
ADDRESS		CITY		STATE																																																																						
BIRTH DATE		HOME TELEPHONE NO.		WORK TELEPHONE NO.																																																																						
HEALTH HISTORY (Please explain any "YES" answers)																																																																										
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<p>Explanation: (Include onset date, diagnosis, medication, physician's name and address and any current condition or limitation. Attach additional sheet, if needed.)</p>																																																																										
This section to be filled out and signed by a HEP/CAMP representative.																																																																										
Students Name			Date of referral		Purchase Order #																																																																					
(Please check which applies) <input type="checkbox"/> Dental <input type="checkbox"/> Physical																																																																										
HEP/CAMP Staff Person			Date		Signature																																																																					

Mendocino Community College
High School Equivalency Program
 1000 Hensley Creek Rd
 Ukiah, CA 95482
 Telephone: 707-467-1026
 Fax: 707-467-1009

PHYSICIAN, CHIROPRACTOR, PHYSICIAN'S ASSISTANT, OR ADVANCED PRACTICE NURSE COMPLETES THIS SECTION

Check each item in appropriate box to show "Qualified" or "Not Qualified." See instructions for condition or defects that must be noted. Explain any special findings or test results **NOT** in an acceptable tolerance range. Use additional sheets, if needed.

Driver License Number	Name	Date of Exam		
ALL BOXES MUST BE COMPLETED		QUALIFIED	NOT QUALIFIED	EXPLANATION IF NECESSARY
Ears. Note any evidence of disease or injury				
Romberg. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Lungs/Chest				
Heart. Stethoscope exam required. Note murmurs, arrhythmias, and any evidence of cardiovascular disease. Electrocardiogram results, if indicated: If organic disease is present, is it fully compensated? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Blood Pressure: Systolic _____ Diastolic _____				
Pulse:				
Abdomen. Note any defects or injuries that could interfere with normal function. Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No If so, where? _____ Is truss worn? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Gastrointestinal. Ulceration or other disease <input type="checkbox"/> Yes <input type="checkbox"/> No				
Spine: Note any disease or injury				
Knee jerk reflex: Right: _____ Normal _____ Increased _____ Decreased Left: _____ Normal _____ Increased _____ Decreased				

STUDENT'S IDENTITY VERIFIED BY: <input type="checkbox"/> California Driver License No. <input type="checkbox"/> Other Photo ID (Specify ID used):		
SIGNATURE OF AUTHORIZED MEDICAL EXAMINER X	DATE OF EXAM	LICENSE OR CERTIFICATE NO./ISSUING STATE
NAME (PRINT)		PLACE DOCTORS'S OFFICE STAMP IN THIS SPACE
TITLE <input type="checkbox"/> Chiropractor <input type="checkbox"/> Advanced Practice Nurse <input type="checkbox"/> Physician (<input type="checkbox"/> M.D. <input type="checkbox"/> D.O.) <input type="checkbox"/> Physician's Assistant	TELEPHONE NO.	
ADDRESS	CITY STATE ZIP	