********** IMPORTANT **********

Instructions

For ALL Students taking the
BOCES 2/CWD Adult Education
Nursing Assistant or Dental Assistant Programs

It is a New York State mandate that in order for you to participate in either of these programs, that the attached medical form be completed and submitted to our office *prior to starting the class*. Below are specific instructions that will assist you in streamlining the process and allow you to start the class on time.

Step 1: Take the attached Medical form to your doctor(s) to have completed.

Step 2: *ALL* fields must be filled out by your doctor(s) in order for you to enter into the "clinical" portion of either program.

Step 3: The medical form *must be signed, dated and stamped by your doctor(s)* in order for BOCES 2/CWD to accept the document.

Step 4: It is *recommended* that you pick up the original medical form from your doctor(s) and make a copy for your record.

Step 5: It is *recommended* that you drop off the medical form to BOCES2/CWD office located at: Rochester Tech Park, 160 Wallace Way, Rochester NY 14624.

Please note that it is *YOUR RESPONSIBILITY* to ensure that this medical form is completely filled out, signed, dated and stamped by your doctor and turned in to the BOCES2/CWD office prior to starting the program. If you have any questions please do not hesitate to call us at (585) 349-9100 for assistance. We look forward to having you enter either our Nursing Assistant or Dental Assistant program.

7/31/2013

MONROE 2 – ORLEANS BOCES

CENTER FOR WORKFORCE DEVELOPMENT – ADULT EDUCATION

MEDICAL EXAM REPORT

Name of Applicant _____

Address _____

Date of Medical Examination (within one year)_____ Date of Birth_____ Age_____

1) Past History: Tuberculosis_____ Heart Disease_____ Frequent colds or sore throat_____
2) Has applicant ever had any convulsions or periods of unconsciousness? _____
3) Vision: Are there any issues? Including color blind ___Yes ___No If yes please clarify _____
4) P.P.D. or proof of vaccination(within one year) _____
5) Orthopedic defects, extremities, etc. _____
6) Hearing: Are there any issues: ___Yes ___ No If yes, please clarify _____
7) Heart and cardiovascular system _____
8) Pulse Rate_____ Blood Pressure: Systolic_____ Diastolic_____
9) Lungs: Check for asthma_____ Tuberculosis (chest X-ray if positive) _____
10) Reflexes_____ Nervous system_____ Tremors, etc. _____
11) Operations and dates _____
12) Genito-Urinary_____ Hernia (actual of potential) _____Type (Inguinal or other) _____
13) Is there any evidence of mental deficiency, alcoholism, or drug addiction? _____
    If yes, state extent of each _____
14) Speech: coherent, incoherent, defect _____
15) Chronic disabilities (cataracts, sinus, rectal diseases, diabetes, arthritis, epilepsy) _____
16) Urinalysis: Sugar_____ Albumin_____ Sp. Gr. _____
17) Any evidence of growths, tumors, etc. (yes or no) _____ (a) If yes, are they malignant? _____
    Are they apt to handicap the applicant in performance of duties? (yes or no) _____
18) MMR #1_____ MMR #2_____
19) Hepatitis Series #1_____ #2_____ #3_____ (Dental ONLY)
20) Seasonal flu_____
21) H. N. flu_____ (optional)
22) Tetanus _____ (within 10 years)

Known Allergies _____

_____ _____

Signature of M.D., Dr's Stamp and Date