

Atlantic Cape Community College
Health Professions Institute
Health Report Form

The following information is required before the start of classes. Please bring this form with you to your doctor's office to insure that you meet all requirements.

Student Name: _____

Required	Date	Results
Physical Exam		
Diphtheria Toxoid		
Measles/Mumps/Rubella		
Hepatitis B		
Tuberculin Skin Test		
Chest X-ray (if positive reactor)		
Drug Test (urine screen)		
Tetanus		

If Female:

Are you currently pregnant? ___no ___yes. If yes, due date: _____

Comments:

Do you feel the student can fulfill the obligations of the program chosen? _____

Physician Signature: _____

Physician Name: (print) _____

Physician Phone Number: _____