Medical Confirmation

Student Name: _____

Program: _____ Start Date: _____

This form certifies that you have acquired a doctor's appointment to have your medical clearance form completed.

Date & Time of Appointment: _____

Physician Name: _____

Office Phone # and Fax # _____

Please attached proof from your doctor's office with confirmation of appointment.

Client Signature: _____ Date: _____

Completing this form, you understand that your medical clearance form must be completed in its entirety and turned into your instructor. _____ Failure to do so will render you ineligible to participate in clinical hours therein unable to complete the program and or receive your certificate of completion.

Westview Commons
3555 Buffalo Road
Rochester, New York 14624

Monroe2boces.org
Office: 585 -349-9100
Fax: 585 -349-9101

Instructions for Completing the Medical Clearance Form

*Students enrolled in the Adult Education programs of **Dental Assistant** or **Nursing Assistant**, please read following information as this pertains to you. .*

It is a **New York State mandate** that in order for you to participate in either of these programs, the attached medical form must be completed and submitted.

Below are the steps that will assist you with completing this form prior to enrollment.

1. Please have the Medical Clearance Form completed by a physician.
2. **ALL** fields must be filled out **by your doctor(s)** prior to entering into the "clinical" portion of either program.
3. The medical form **must be signed**, **dated and stamped by your doctor(s) in order for BOCES 2/CWD to accept the document.**
4. It is **recommended** that you pick up the original medical form from your doctor(s) and make a copy for your records.
5. It is **recommended** that you drop off the medical form to the BOCES 2/CWD office located at 3555 Buffalo Road, Rochester NY 14624.

   You may have your physician fax it with your proper consent to: (585) 349-9101 Attention: Admissions.

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 BOCES 2/CWD office.

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Medical Clearance Form

Student Name: _____ **DOB:** _____

Student Address: _____

Tel#: _____ **Email:** _____

Date:	Height	Blood Pressure	Weight	Pulse

Please circle findings. Comment only if abnormal. **All Information must be up to date and within the last 6 months **

HAND/SKIN: Normal / Abnormal

Comment: _____

HEAD/EYES: Normal / Abnormal

Comment: _____

EARS/NOSE/THROAT/MOUTH: Normal / Abnormal

Comment: _____

NECK/NODES: Normal / Abnormal

Comment: _____

CHEST/LUNGS: Normal / Abnormal

Comment: _____

CARDIO/VASCULAR: Normal / Abnormal

Comment: _____

ABDOMEN: Normal / Abnormal

Comment: _____

MUSCULOSKELETAL/EXTREMITY/SPINE: Normal / Abnormal

Comment: _____

NERVOUS SYSTEM/SEIZURE DISORDER: Normal / Abnormal

Comment: _____

GENITO/URINARY: Normal / Abnormal

Comment: _____

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Your Educational Partner of Choice
BOCES 2

MONROE 2-ORLEANS BOCES
CWD
Center for Workforce Development
ENGAGE EDUCATE EMPOWER

Student Name: _____ **DOB** _____

MMR (Measles, Mumps, Rubella)				**Dental Assistant & Nurse Assistant**
HEP A Vaccine (series)				**Optional**
HEP B Vaccine series)				**Dental Assistant**
DTaP (Diphtheria, Tetanus, Pertussis) Vaccine				**Dental Assistant & Nurse Assistant**
Influenza Vaccine (seasonal)	**Date:** **Lot #**	***	***	**Nurse Assistant**
PPD SKIN TEST **Date Placed :**	**Date Read:**	**Read By :**	**Lot Number #**	**Dental Assistant & Nurse Assistant**

Please notate the date of Vaccination & Lot number, or proof Titer.

Positive PPD, chest X-ray results Date:

_____

Result (circle one): Normal / Abnormal (Mo/Day/Yr.)

Does this patient suffer from any chronic physical or mental disabilities and or limitations that would interfere with patient care for a period of 6 hour to 12 hour working days?

YES or NO**, if YES, please explain**:

_____

_____

To the best of my knowledge the above-named patient has been medically cleared to participate in clinical work and/or education at this time.

Physician's Name: _____

Date

Physician's Signature: _____

Physician's Office Stamp: ***Date***

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