SANTA BARBARA CITY COLLEGE

EMT Physical Exam Form

To be completed by primary health care provider

Student Name _____

Student K#_____

Height_____ Weight_____

Blood Pressure _____/_____

Pulse _____ Resp _____ Temp _____

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE COLUMN	DESCRIPTION OF ANY ABNORMALITIES
		Eyes	
		Ears – (Tympani, Canals, Discharge)	
		Nose	
		Mouth (teeth)	
		Throat (tonsils)	
		Neck	
		Chest (include breasts)	
		Lungs	
		Heart	
		Abdomen	
		Extremities	
		Varicose Veins	
		Feet (arches)	
		Spine (alignment, R.O.M.)	
		Neurologic	
		Skin/Scars	
		Rectal/Vaginal if indicated by history	
R_____L_____	R_____L_____	Hearing	
YES	NO	Is Hernia present?	
YES	NO	Does applicant appear healthy & alert?	

1. Do you believe that this individual is and will likely be mentally and physically capable of pursuing a Health Technology program? Yes_____ No_____

If No, please explain_____

_____

2. Does he/she have any health related condition that would create a hazard to him/herself, fellow employees, patients, or visitors? Yes_____No_____

If Yes, please explain_____

_____

Signature _____M.D. Date_____

PHYSICIAN'S STAMP & ADDRESS

SANTA BARBARA CITY COLLEGE
EMT Physical Exam Form

Student Name _____

To be completed by the student

A. Diseases or conditions you have had or have now: (give approximate dates)

Abnormal Back X-ray_____
Abnormal Bleeding_____
Abnormal Chest X-ray_____
Abnormal EKG_____
Alcoholism_____
*Allergies_____(list below)_____
Anemia_____
Arthritis_____
Asthma_____
Back Problems_____
Back Strain_____
Blurred Vision_____
Breathing Problems_____
Bronchitis_____
Cancer_____
Colds (frequent)_____
Constipation_____
Convulsions_____
Deformity_____
Diabetes_____
Dizzy Spells_____
Ear Aches_____
Emotional Illness_____
Epilepsy_____
Excessive Fatigue_____
Eye Problems_____
Fainting Spells_____
Frequent Cough_____
Frequent Headaches_____
Frequent Urination_____
Gallbladder_____
Gastric Ulcer_____
GI Bleeding_____
Hearing Problems_____
Heart Disease_____
Hepatitis_____
Hernia_____
High Blood Pressure_____
Jaundice_____
Joint Problems_____
Kidney Disease_____
Knee Problems_____
Liver Problems_____
Loss of Appetite_____
Menstrual Difficulties_____
Migraine_____
Mononucleosis_____
Neck Problems_____
Nervousness_____
Pain/Swollen Testicles_____
Palpitations_____
Polio_____
Rheumatic Fever_____
Skin Disease/Itching_____
Thyroid Disease_____
Tuberculosis_____
Varicose Veins_____

Sensitivity / Allergy to LATEX Yes_____No____ If yes, describe:_____

*Allergies:_____

Remarks:_____

B. List:
1. Any serious illness you have had – and date(s)_____
2. Any surgeries you have had – and date(s)_____
3. Any injuries you have had – and date(s)_____
4. Do you smoke?_____How much?_____
5. Do you drink alcohol?____How much / often?_____

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C. Are you under a doctor's care now?_____Name of Doctor_____
Reason for care_____

D. List medications taken regularly_____

I HEREBY CERTIFY THE FOREGOING RESPONSES TO BE TRUE:

DATE:_____SIGNATURE OF APPLICANT_____

Please hold on to your physical exam until advised

07/29/2025