HEALTH EXAMINATION BY PHYSICIAN

Massage Therapy

Name of applicant _____

Date of birth _____ Weight _____ Height _____

PLEASE CHECK THE APPROPRIATE PROGRAM.

☐ **MASSAGE THERAPY**

I. Do you have a history of diseases of the following?

Please answer **YES** or **NO**.

If you answer **YES** – please explain:

	Yes	No	Explanation
Skin			
Eyes/Vision			
Ears/Hearing			
Cardiac			
Lungs/Respiratory Illness			
Musculoskeletal			
Diabetes			
Neurological/Seizures			
Abdominal (Hernias)			
Vascular (Varicose Veins)			
Allergies			

List any medication or drugs taken frequently.

_____

Physical activity limitations?

Yes _____ No _____ Explain: _____

II. Please provide dates of either immunization or proof of immunity of the following:

	Proof of Immunity (Titer) or Date of Immunization/s
Measles (rubeola) • 2 live vaccinations after 1st birthday	
Mumps • 2 live vaccinations after 1st birthday	
Rubella (German Measles) • 1 live vaccination after 1st birthday	
T-DAP	**Date of immunization:**
Varicella (Chicken Pox)	

** If you were given the immunization prior to 1975 you may wish to protect yourself by having the immunization repeated.*

** Some clinical affiliates may ask for a titer.*

III. DO YOU CONSIDER THE APPLICANT PHYSICALLY AND EMOTIONALLY ABLE TO UNDERTAKE A PROGRAM IN THE HEALTH SCIENCES?

YES _____ NO _____

REMARKS:

Physician's Name _____

Office Address _____

Telephone _____

_____ _____

Physician's Signature *Date of Examination*

*****Cost of the physical examination, laboratory tests and immunizations assumed by applicant.**

PLEASE RETURN THIS FORM TO THE <u>APPROPRIATE PROGRAM DIRECTOR</u> AT:

Washington State Community College
710 Colegate Drive
Marietta, Ohio 45750

Revised: January 2019