B&H Emergency Medical Training

Physician Attestation Letter

Patient's Name: _____ Date of Exam: _____
Last First

I. **Pertinent Patient Information**

Date of Birth: _____ _____ _____
Month Day Year

History of Chickenpox (Varicella) Yes [ ] No [ ]

List current condition for which patient is under treatment: _____

_____

List all medications: _____

II. **Physical Examination: To the best of your knowledge:**

Was the patient's physical examination:? Normal [ ] Abnormal [ ] If abnormal, describe findings: _____

_____

Is the patient free from mental impairments? Yes [ ] No [ ] If no, describe findings: _____

_____

Is the patient free from physical impairments? Yes [ ] No [ ] If no, describe findings: _____

_____

Is the patient free from habituation or addiction to depressant, stimulants, narcotics, alcohol, or other behavior altering substances? Yes [ ] No [ ] If no, explain: _____

III. **Influenza (Flu Shot)** Date:_____

IV. **PPD (5TU)** Date: _____ Negative [ ] Positive [ ] (_____mm induration)

Chest X-Ray Results (For PPD positive individuals only) _____ Date: _____

V. **Rubella Status:** Immune [ ] Not Immune [ ] Vaccination Date: _____

VI. **Rubeola Status:** Immune [ ] Not Immune [ ]

Was vaccine administered? Yes [ ] No [ ] Dates: _____ Types: _____

Documentation of physician diagnosis measles attached: Yes [ ] No [ ]

Copy of laboratory titer showing serologic immunity: Yes [ ] No [ ]

Physician Attestation Letter (Continued)

I. **Does the patient have any physical, medical, infectious or other condition or disability that would preclude the student's participation in a hospital clinical rotation**? Yes [ ] No [ ] If yes, explain: _____

_____

II. **Hepatitis B Vaccine (Optional):** Has the patient received a Hepatitis B Vaccination series? Yes [ ] No [ ]

Dates: 1st _____ 2nd _____ 3rd _____

III. **Name of Examining Physician:**

I have determined that the above patient is free from any health impairment which is of potential risk to patients or which might interfere with the performance or his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Name: _____ Signature: _____
Please Print First and Last Name

Office Phone Number: _____ License Number: _____

Office Address: _____
Number Street City State Zip

Patient Release Form

I, _____, hereby authorize the above named physician to furnish my Health History and Medical Records to the Course Sponsoring Agency and to any hospital, or other clinical site as required by Title 10 and other governing agencies.

Students Signature: _____ Date: _____