Academy of Chinese Culture and Health Sciences

Tui Na Massage Therapy Certificate Program

ACCHS Student Health Information

TO BE COMPLETED BY PHYSICIAN

NAME OF APPLICANT_____DATE OF EXAM_____

HT_____ WT_____ TEMP_____ PULSE_____ BP_____
HEAD & NECK _____
BENT _____
MOUTH _____
CHEST _____
LUNGS _____
HEART _____
ABDOMEN _____
GENITALIA _____
EXTREMITIES _____
SKIN _____
NEUROLOGIC _____

REMARKS: _____

_____

CONCLUSION:
_____

_____

TB SKIN TEST GIVEN: YES _____ NO _____
IF NO, X-RAY ORDERED : YES _____ NO _____
RESULTS OF TB SKIN TEST: _____ RESULTS OF X-RAY:_____
FOLLOW-UP TO ANY POSITIVE RESULT _____

_____

On the basis of my medical examination, (date) _____
the above named individual for the position of health care provider in a Community Teaching Clinic

PHYSICIAN'S SIGNATURE:_____

PHYSICIAN TYPED OR PRINTED NAME:_____

PHYSICIAN LICENSE #_____

ADDRESS: _____

TELEPHONE: _____

THIS FORM IS TO BE RETURENED BY THE EXAMINING PHYSICIAN DIRECTLY TO THE ACADEMY OF CHINESE CULTURE AND HEALTH SCIENCES