

**PORTLAND COMMUNITY COLLEGE
OPHTHALMIC MEDICAL TECHNOLOGY
STUDENT HEALTH FORM**

Mail to:

Health Professions Admissions
Portland Community College
705 N Killingsworth St.
Cascade JH 210
Portland OR 97217

Student Name _____ Date _____

Student Birthdate _____

To the best of your knowledge:

- 1. Is this student free from communicable diseases? YES NO
- 2. Has this student had a tetanus shot within the past 10 years? YES NO
- 3. Has this student had the usual inoculations? YES NO
- 4. Please indicate the results of a current TB test: Positive Negative
- 5. Are you aware of any physical limitations of this student? YES NO

In your opinion, is this student able to meet the technical standards of the Ophthalmic Medical Technology program as outlined?

YES

NO

Signed: _____, M.D./D.O./P.A./R.N.P

Address: _____

Phone: _____