Medical Professional Institute
380 Pleasant Street
Malden, MA 02148
(781) 397-6822

Allied Health Application Documentation

Thank you for your interest in pursuing an education through Medical Professional Institute (MPI). Our Allied Health department consists of training in Medical Assisting or Phlebotomy & Electrocardiography.

Anyone wishing to attend MPI must complete a Pre-Application Assessment and interview process. Prospective students must also come prepared with several documents.

These documents include, but are not limited to:

- **High School Diploma or GED** – A valid high school diploma is required for anyone who plans to attend classes at MPI. If an applicant has attended high school in a different country they must have an equivalency evaluation done of their diploma through the Center for Education Documentation (CED). Online high school diplomas are not valid. Anyone who has an invalid diploma or no diploma at all must complete the General Education Development (GED) test.

  **NOTE: MPI must have proof of a high school graduation date. College diplomas are not valid and will not be accepted.*

- **Completed Physical Examination and Immunization Record Form** – Attached is a Report of Physical Examination and Immunization Record Form. This form is to be fully completed by each prospective student's primary care physician before class orientation. Print the form and bring it to your doctor. In order to start classes this form must be handed in no later than the given date of orientation.

Medical Professional Institute
EDUCATION FOR THE REAL WORLD™

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380 Pleasant Street o Suite 21 o Malden, MA 02148

DUE BY: _____

REPORT OF PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

Please complete the following physical examination information and immunization record and return to student. The exam must be done wit in the last 12 months.

STUDENTS FIRST NAME (Please Print) MIDDLE NAME LAST NAME (MAIDEN)

DATE OF EXAM: _____ (must be within 1 year from start date)

☐ Male ☐ Female DATE OF BIRTH: _____

Age _____ Height _____ Weight _____

Blood Pressure _____ Pulse _____

Result of Exam: _____

Hearing: ☐ Normal ☐ Abnormal

If abnormal, please explain and specify if corrected: _____

Vision: Able to See? ☐ Yes ☐ No Color Blind? ☐ Yes ☐ No

Corrected? ☐ Yes ☐ No Contact Lenses/Glasses: ☐ Yes ☐ No

Does the student have any medical conditions? : ☐ Yes ☐ No

If yes, please list and explain: _____

Is the patient now under treatment for:

a) Serious Medical Condition ☐ Yes ☐ No

b) Serious Emotional Condition ☐ Yes ☐ No

List Medications Currently Taking (If Any): _____

List Allergies (If Any): _____

Are you this patient's regular physician? ☐ Yes ☐ No

Do you have any recommendations regarding the care of this student?

Additional Comments: _____

PHYSICIAN'S NAME PRINTED _____

ADDRESS _____

TELEPHONE NUMBER (_____) _____

PHYSICIAN'S SIGNATURE _____

DATE FORM COMPLETED _____

REQUIRED IMMUNIZATIONS

MMR Vaccination – Must have **2** doses

Vaccine 1 _____/_____/_____ (Month Day Year)

Vaccine 2 _____/_____/_____ (Month Day Year)

-OR-

Measles (Rubeola) – Must have **1** of the following:

Date of Disease _____/_____/_____ (Month Day Year)

AND

Date of Titer Proving Immunity _____/_____/_____ (Mont Day Year)

OR

Dates of Vaccinations Dose 1 _____/_____/_____ (Month Day Year)

Dose 2 _____/_____/_____ (Month Day Year)

Rubella (German Measles) – Must have **1** of the following:

Date of Disease _____/_____/_____ (Month Day Year)

AND

Date of Titer Proving Immunity _____/_____/_____ (Month Day Year)

OR

Date of Vaccination (1 Dose) _____/_____/_____ (Month Day Year)

Mumps – Must have **1** of the following:

Date of Disease _____/_____/_____ (Month Day Year)

AND

Date of Titer Proving Immunity _____/_____/_____ (Mont Day Year)

OR

Date of Vaccination (1 Dose) _____/_____/_____ (Month Day Year)

Tetanus, Diphtheria or Tdap - booster dose given within the **last 10** years.

_____/_____/_____ (Month Day Year)

Hepatitis B - series, waiver or proof of immunity required

Dose 1 _____/_____/_____ (Month Day Year)

Dose 2 _____/_____/_____ (Month Day Year)

Dose 3 _____/_____/_____ (Mont Day Year)

OR

Date of Titer Proving Immunity _____/_____/_____ (Month Day Year)

PPD Test – Must have had **within 1 year** from start date

Date PPD was Planted _____/_____/_____ (Month Day Year)

Date PPD was Read _____/_____/_____ (Month Day Year) Result: _____ mm

If Positive Result, Date of Chest X-Ray _____/_____/_____ (Month Day Year)

Result: _____

Varicella (Chicken Pox) – must have **one** of the following:

Dates of Vaccinations Dose 1 _____/_____/_____ (Month Day Year)

OR Dose 2 _____/_____/_____ (Month Day Year)

Date of Titer Proving Immunity _____/_____/_____ (Month Day Year)

OR

Date of Disease _____/_____ (Month Year)

Influenza

Date of Vaccine _____/_____/_____ (Month Day Year)

Student Signature _____ **Date:** _____