



HEALTH RECORD

PLEASE PRINT ALL INFORMATION

Physical Examination: Must be performed by Physician, Nurse Practitioner or Physician's Assistant

Name: _____ D.O.B. _____
Last First M.I.

Allergies: _____

Medications: _____

Height: _____ Weight: _____ Pulse: _____ B/P: _____

EXAMINER: Indicate your findings after examination of each system

EENT: _____

NEURO: _____

CV: _____

RESP: _____

ENDOCRINE: _____

MUSC/SKEL: _____

- If this student has any reaction to latex, please complete the Examiner's portion of the "Latex Reaction Form" supplied by the student.
- If this student is subject to any health emergency, please provide special emergency instructions below:
- If there is additional significant information about this student which would relate to his or her safety for patients or for self in a clinical or laboratory situation, please provide additional information below.

Does student have any functional limitations or restrictions that would prevent him/her from working in a patient care area?	Yes	No
Vision, such as reading gauges or thermometers?		
Hearing, such as in a classroom or when using a stethoscope?		
Speech, such as in a classroom?		
Lifting up to 50 pounds?		
Ambulation/Standing for several hours?		
Ability to handle stress?		
Sensorimotor (fine and gross)?		

Does the student have any limitations or restrictions? If, no, please document below "No Restriction/ No Limitation". If Yes, please provide specific facts regarding student's requirements. _____

Examiner's Signature: _____ Date: _____

Printed Name: _____

Address: _____ Phone _____