Name_____DOB_____PeopleSoft # _____ Program_____

PART 2: Physical Examination – To be completed by healthcare provider

Note: All items are required except where indicated as optional.

VITAL SIGNS

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _

CHECK NORMAL/ABNORMAL FOR EACH AREA

	Normal	Abnormal	Description of Abnormal Findings
Appearance			
Nutrition			
Skin			
Head/Neck			
Glands			
Eyes			
Ears			
Nose			
Mouth/Teeth/Throat			
Chest			
Lungs			
Heart			
Abdomen			
Back			
Musculo-Skeletal			
Testes (Optional)			
Genitalia/Pelvic (Optional)			
Neurological			
Emotional/Psychological			

COLOR VISION screening is required unless otherwise indicated on your instruction page.

Color Vision (6-plate minimum)	
☐ Normal	☐ Deficient

Healthcare Provider Attestation of Student Fitness for Participation in Clinical Experiences

I have reviewed this student's health history and conducted a physical examination. The information presented on this form is true and accurate to the best of my knowledge. It is my opinion that this student is in satisfactory physical condition to participate fully in clinical experiences required by the program of study. I have noted any limitations below.

Limitations:_____

_____

The information presented on this form is true and accurate to the best of my knowledge.

Provider Signature:_____ **Date:**____/____/____ **Phone:**_____

Provider Name (printed):_____ **Address:**_____

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA