PHYSICAL EXAMINATION BY MEDICAL PRACTITIONER

Please print in black ink – Complete all of the following:

____

Last Name | First Name | Middle Name | Date of Birth (mo/day/year) | ID or SS#

Height __________ Weight __________ TPR _________ / _________ / _________ BP _________ / _________

VISION:

Corrected Right 20/ __________ Left 20/ __________

Uncorrected Right 20/ __________ Left 20/ __________

Color Vision ____________________________

HEARING:

(gross) Right ___________ Left ___________

15 ft. Right ___________ Left ___________

A. Is there loss or seriously impaired function of any single or paired organs? Yes _______ No _______

Explain:____

____

____

B. Is student under treatment for any medical or emotional condition? Yes _______ No _______

Explain treatment/medication:____

____

____

C. Recommendation for physical activity (during patient care activities) Unlimited______ Limited ______

Describe limitation: ____

____

Based on my assessment of this student's physical and emotional health on __________________, he/she

(date)

appears to be able to participate in the activities of a health profession in a clinical setting and provide safe care

to the public. YES _______ NO _______

If no, please explain

____

____

____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

____

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

____

Office Address **City** **State** **Zip Code**