Name: _____ **DOB:** _____ **PeopleSoft #:** _____ **Program:** _____

PART 1 – Physical Exam

To be completed and signed by healthcare provider. *All items required unless marked optional.*

VITAL SIGNS

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

CHECK NORMAL/ABNORMAL FOR EACH AREA (if abnormal, please include description)

	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 (6-plate minimum)

Color Vision screening is required for all Allied Health Sciences & Nursing programs (including Long-Term Care Administration). Optional for other programs. ☐ Normal ☐ Deficient

N95 Respirator Mask Fit Test Clearance

Student is cleared to be fitted for N95 or other respirator mask & to wear it while caring for patients. ☐ Yes ☐ No
Note that a fit test is not required, only clearance for a potential future fit test if necessary.

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 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 (if any): _____

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

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

Provider Type: ☐ MD ☐ DO ☐ APRN ☐ PA