





Physical examination; titers and immunizations will be at the student's expense.

**PHYSICAL EXAMINATION – To be completed by physician of choice.**

Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: Without correction Right: 20/ \_\_\_\_\_ Left: 20/ \_\_\_\_\_

With correction (if any) Right: 20/ \_\_\_\_\_ Left: 20/ \_\_\_\_\_

System Assessment	Normal	Abnormal	Briefly Describe Abnormalities
Cardio-Vascular			
Respiratory			
Digestive			
Nose & Throat			
Ears (hearing)			
Eyes (vision)			
Nervous System			
Bones & Joints			
Breasts			
Abdomen			
Back			

1. Is this student capable of normal physical exercise?  Yes  No

If No, please explain:

\_\_\_\_\_  
\_\_\_\_\_

2. Is this student presently under medical, neurological or psychiatric treatment?  Yes  No

If Yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

3. Are there any physiological and/or psychological limitations that would restrict this individual's participation in the college nursing program?  Yes  No

If Yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

EXAMINER'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Please print name: \_\_\_\_\_

ADDRESS: Street / City / Zip \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_  
PHONE