***Physical Exam must be completed annually. Both pages must be uploaded to the tracker.**

Physical Exam

Part I: Personal Data/Medical History. To be completed by the student.

Patient Full Name_____

Sex M ____ F ____ Age _____ Birth Date _____ GSW ID# _____

Height_____ Weight _____ Marital Status S____ M____ D____ W____ Cell # _____

Address _____City/State/Zip _____

E-mail addresses _____

Emergency Contact Name: _____

Home Phone (_____) _____ Work Phone (____)_____ Cell Phone (_____) _____

Relationship to patient: ____ Parent ____ Guardian ____ Spouse ____ Other

MEDICAL HISTORY

List medication to which you are allergic and give dates and descriptions of reactions. (If "none" please indicate.)

_____

_____

List and give dates (by occurrence or onset) of any major illnesses or hospitalizations you have had. (If "none" please indicate.)

_____

_____

List and give dates of significant injuries or surgery. (If "none" please indicate)

_____

_____

List medication you are taking. (Include oral contraceptives, allergy injections, herbals, etc. If "none" please indicate.)

_____

_____ _____

Do you have any physical or mental challenges or conditions* that may impact your activity? Yes ____ No _____

*See the Essential Technical Standards in the Student Handbook. All nursing students must demonstrate the ability to meet the Essential Technical Standards with reasonable accommodation upon admission and throughout the nursing program.

To the best of my knowledge, all medical history statements are true with no abnormality, limitations, or restrictions not mentioned in this record. The School of Nursing will be notified of changes in physical or mental health prior to registration and throughout my enrollment in the nursing program.

Patient Signature _____Date_____

Student Name _____ GSW ID _____

Part II. To be completed by physician or certified nurse practitioner and returned prior to beginning the nursing program. Back of form may be used for additional comments when necessary.

1. Vision normal with correction ( ) without glasses ( ) Color vision defective? No ( ) Yes ( )

2. Hearing normal? No ( ) Yes ( )

3. Blood Pressure_____Within normal limits? No ( ) Yes ( )

4. Height_____inches Weight_____ pounds BMI_____

5. Physical Examination Comment on abnormalities on back of form

System	Normal	Abnormal	System	Normal	Abnormal
Skin			Abdomen		
Head, Face, Neck			Endocrine System		
Nose & Sinuses			Spine		
Mouth & Throat			Neurological		
Teeth			Genitalia		
Lungs & Chest			Breasts		
Heart			Pelvic if indicated		
Vascular System			Hernia		
Mental Status					

9. Are there any known mental or physical health problems that would affect progress in the nursing program or participation in clinical nursing activities?
No ( ) Yes ( ) If yes, please specify on back of form

10. Are there allergies that could be exacerbated by clinical environment or activities?
No ( ) Yes ( )

TO MY KNOWLEDGE, THE INFORMATION I HAVE SUPPLIED ON THIS HEALTH FORM IS ACCURATE AND COMPLETE

_____ _____
Signature of Physician or Certified Registered Nurse Practitioner Date

Please print or type provider's name_____

Medical Office Address Sticker of Stamp Required_____