Student Name (printed- Last, First)_____ Date: _____

Felbry College School of Nursing

6055 Cleveland Avenue, Columbus OH Tel. (614) 781-1085 Fax: (614) 929-3816 www.felbrycollege.edu

PHYSICAL EXAM

**** PRINT TO COMPLETE FORM USING BLACK INK ONLY****

Last Name:	First Name:	Date of Birth:	Sex: ___ Male ___ Female
Address:	City:	State:	Zip:
Height (in.):	Blood Pressure:	Heart Rate:	Respiratory Rate:
Weight (lbs.):	Temperature:	Vision- Left Eye:	Vision-Right Eye:
Allergies:		Current Medications:	

System	Normal	Abnormal	Comments	System	Normal	Abnormal	Comments
Nose, Mouth				Endocrine			
Throat, and Neck				Respiratory			
Mouth, Teeth, and Gums				Gastrointestinal			
Eyes				Cardiovascular			
Ears				Musculoskeletal			
Skin				Genitourinary			
Lymphatic				Neurologic			

Based on a complete physical examination, it is my professional opinion that this individual is capable of participating, without hazard, in clinical practice settings.

Provider Information and Verification

Name of Physician (Print or Type): _____

Signature of Physician:_____

Examination Date: _____

Name of Hospital/Clinic/Practice: _____

Affix Provider Stamp Here:

Student Name (printed- Last, First)_____ Date: _____

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Vaccination/ Immunization Record

Copies of actual lab results must be attached.

Test	Date ***Mark "NOT COMPLETED HERE" if the testing was done at another facility.***	Result	
TB Skin Test #1 Required *		_____ mm	
TB Skin Test #2 Required *		_____ mm	
Only For history of positive TB Skin Test		Indicate date of most recent chest x-ray and attach copy of radiologist report	Date of X-ray:
Rubeola		Does titer result constitute immunity? Yes___ No____	
Rubella		Does titer result constitute immunity? Yes___ No____	
Mumps		Does titer result constitute immunity? Yes___ No____	
Varicella		Does titer result constitute immunity? Yes___ No____	
Tdap, Dtap			
Hepatitis B			

* 2 step TB skin test is required unless the 1st step is found to be positive. In case of positive TB skin results an X-ray done in the last 5 years is necessary.

Provider Information and Verification

Name of Physician (Print or Type): _____

Signature of Physician:_____

Examination Date: _____

Name of Hospital/Clinic/Practice: _____

Affix Provider Stamp Here: