Student Physical Examination Form

Student Name:_____

Date:_____

To be returned to: All American Nursing School
12250 S Cicero
Alsip, IL 60803
(708)396.8409

_____ A. Physically able to perform essential functions: of nursing, based on medical examination.

_____ B. Based upon a high probability of substantial harm, this individual would pose a direct threat to self or others.

Signature for above documentation:

_____
Health Care Professional's Signature Date

_____
Print Name Phone Number

_____
Address

Signature of verification:
I confirm that to the best of my knowledge the information recorded above is correct and that the health care professional whose signature appears is qualified to provide these assurances.

_____
Student Signature Date

Physical Examination Form

Student Name: _____ Sex: □ M □ F Birth date:_____

Program Location: _____ □ Weekday □ Saturday

Have you had a serious illness, injury or surgery? □ Yes □ No If yes, please describe:

_____

_____

TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER

1. Current complaints/disabilities pertinent to the student's participation in training program.

_____

_____

2. Medication used: Prescription and over-the-counter (use back if necessary)

Name	**Indication**	**Frequency**

_____

_____

3. Significant medical history, accidents, deformities, surgeries, back problems, communicable diseases:

_____

_____

4. Examination Comments and findings:

_____

_____

_____

Assessment of Systems

Name:_____ Age: _____ Date:_____

VITALS

Height:_____ BP: _____ Temperature:_____

Weight:_____ Pulse:_____ Respirations:_____

PHYSICAL EXAM	NORMAL Yes	NORMAL No	COMMENTS
General Appearance			
Head			
Face (Note deformity, facial hair)			
Eyes			
EOM's			
Pupils (Size, reactivity, accommodation)			
Fundi (Optional			
Ears (Inspection)			
Nose			
Mucous membranes			
Deformity			
Oropharynx			
Neck			
Thyroid			
Nodes			
Notion			
Chest (Inspection			
Lungs			
Expansion			
Auscultation			
Percussion			
Heart			
Percussion			
PMI			
Rhythm			
Auscultation			
Lymphatics			
Supraclavicular			
Epitrochlear			
Inguinal			
Axillary			
Abdomen			
Percussion			
Palpation			
Organ Size			
Auscultation			
Scars			
Hernia			
Genitalia (Optional as indicated by history)			

Name:_____ Age: _____ Date:_____

PHYSICAL EXAM	NORMAL Yes	NORMAL No	COMMENTS
Urethral Discharge			
Rectum, Prostate, Occult Blood			
(Optional as indicated by history)			
Spine			
Inspection			
Flexion			
Extension			
Side Bend			
Rotation			
Palpation			
Shoulders			
Overhead Extension			
Abduction			
Palpation			
Deformity			
Elbows/Wrists			
Motion			
Palpation			
Deformity			
Hands/Fingers			
Grasp			
Deformity			
Lower Extremities			
Feet			
Ankles			
Knees			
Hips			
General			
Neurological			
DTS's			
Romberg			
Focal Weakness			
Focal Sensory Defect			

Please comment on all abnormal findings:

_____

_____

_____

Medical Evaluator:_____

Medical Evaluator's Signature: _____ Date: _____