



Felbry College School of Nursing

6055 Cleveland Avenue, Columbus OH Tel. (614) 781-1085 Fax: (614) 917-1010 www.felbrycollege.edu

PHYSICAL EXAM

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

Last Name:			First Name:			Date of Birth:			Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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:



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Vaccination/ Immunization Record

Copies of actual lab results must be attached.

Test	Date		Result	
	<i>Mark "NOT COMPLETED HERE" if the testing was done at another facility.</i>			
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

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Signature of Physician: _____

Examination Date: _____

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