



Annual Physical Examination
(To be completed by a licensed Healthcare Provider)

Student's Name: _____ Today's Date: _____

Height: _____ Weight: _____ B.P.: _____ Pulse: _____ Temp: _____

Visual Acuity: O.D. _____ Corrected: _____ O.S. _____ Corrected: _____

SYSTEM	Normal	Abnormal	Remarks (Describe Abnormalities)
Skin			
HEENT			
Hearing			
Thorax & Lungs			
Heart & Vascular			
Lymphatics			
Abdomen			
Genitourinary			
Musculoskeletal/Spine			
Neurologic			
Mental/Emotional			

Does this student have any physical limitations that would prevent them from providing care as a nurse?

Yes No

If yes please explain, if no mark N/A: _____

Additional Comments: _____

Provider Name: _____ License #: _____ State: _____

Signature: _____ Agency Name: _____

Agency Address: _____ Agency Phone #: _____