**Health Exam**

**Salisbury University**

**School of Nursing**

***TO BE COMPLETED BY HEALTH CARE PROVIDER***

**APPLICANT INFORMATION:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Middle

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age Birth date ID #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height Weight Temperature‑Pulse‑Respiration Blood Pressure

**PHYSICAL EXAM:**

|  |  |
| --- | --- |
| Skin, Hair & Nails | Heart & Blood Vessels   |
| Head | Abdomen |
| Eyes Vision: WNL? Yes \_\_\_ No \_\_\_\_ Corrective lenses? Yes \_\_\_ No \_\_\_\_ | Genital-Rectal    |
| Ears Hearing: WNL? Yes No \_\_\_\_ Correction Required? Yes \_\_\_\_ No \_\_\_\_ | Musculo‑skeletal |
| Nose & Sinuses | Lymphatics |
| Throat & Mouth  | Neurological   |
| Neck | General Assessment Summary  |
| Chest & Lungs | Any restrictions for clinical nursing?  |
| Breasts & Axillae |  |

Upon completion of this physical exam, I have found to be in adequate

health to participate in clinical experiences.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Signature Health Care Provider (printed name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Address

Date : Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_