CLARK COLLEGE
Health Services
1933 Fort Vancouver Way – HSC 124
Vancouver, WA 98663
(360) 992-2264, Fax (360) 992-2853

Program (please circle)

Dental Hygiene   Nursing

Medical Radiography   Pharmacy Tech

Medical Assistant

STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of this physical exam and any attached documentation to Clark College Health Services, for the sole purpose of evaluating compliance with the requirements of the specific program

Student Signature ________________________________ Date_________________

Student Name (please print) ____________________________ Date of Birth ________________

VITAL SIGNS & MEASUREMENTS:

Height: ___________________   Weight: ___________________

Pulse Rate: ___________________   Blood Pressure: ___________________

SCREENING TESTS & LAB DATA (**if indicated**):

Vision: R 20/ _____   L 20/ ____

Urinalysis: ______________________________   Hematocrit/Hemoglobin: ________________

Cholesterol Total _______ HDL _______ LDL _______ VLDL _______

SIGNIFICANT MEDICAL HISTORY AND REVIEW OF SYMPTOMS:

Family History

Past Medical History (surgeries, illnesses, injuries, allergies)

Personal/Social History (ETOH, smoke, BCM)

Current Health (meds, allergies, concerns, limitations)

EXAM

NAME ____________________ DOB ____________________

General Appearance: ____________________

Skin, Hair, Nails: ____________________

Head, Neck, Thyroid: ____________________

Eyes, Pupils, EOM: ____________________

Ears: ____________________

Nose: ____________________

Mouth, Throat: ____________________

Teeth: ____________________

Chest, Lungs: ____________________

Breasts: ____________________

Heart: ____________________

Vascular System: ____________________

Abdomen: ____________________

Musculoskeletal: Upper extremities ____________________

Lower extremities ____________________

Neck and back ____________________

Neurological: ____________________

Vagina, Cervix, Uterus (**if indicated**) ____________________

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____

Penis, Testicles, Hernia: ____________________

I certify that this individual is approved for the stated program

☐ with no restrictions ☐ with the following restrictions

____

____

Provider Name: ____________________ **(please print)**

Provider Address: ____________________

____

(signature) ____________________ ____________________

Physician/Nurse Practitioner/Physician Assistant Date