

PHYSICAL EXAMINATION FORM FOR HEALTH SCIENCE PROGRAMS

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 Name (please print) _____ Date of Birth _____

Student Signature _____ Date of Exam _____

VITAL SIGNS & MEASUREMENTS:

Height: _____

Weight: _____

Pulse Rate: _____

Blood Pressure: _____

SCREENING TESTS & LAB DATA (if indicated by provider):

Vision: R 20/ ____ 20/ ____

Urinalysis: _____

Hematocrit/Hemoglobin: _____

Cholesterol Total _____ HDL _____ LDL _____ VLDL _____

SIGNIFICANT MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Family History

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

Personal/Social History (ETOH, smoke, BCM)

Current Health (meds, allergies, concerns, limitations)

NAME _____ **DOB** _____

PHYSICAL EXAM:

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**) _____

Penis, Testicles, Hernia: _____

I certify that this individual is approved for the stated program: with no restrictions OR

with the following restrictions: _____

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

Provider Address: _____

Signature
Physician/Nurse Practitioner/Physician Assistant

Date