School Physical Examination

Last Name **First Name** **Middle Initial**

	Normal	Abnormal	Comments
1. General Appearance			
2. Skin			
3. Eyes			
4. Ears/Nose/Throat			
5. Hearing			
6. Lymph Nodes			
7. Respiratory			
8. Cardiovascular			
Blood Pressure			
Pulse			
9. Abdomen/G.I.			
10. Musculoskeletal			
11. Joints/Extremities			
12. Neurological			
13. Metabolic/Endocrine			
14. Other			

Is the student receiving medication or treatment for any health-related problems that may impair his/her ability to perform their clinical duties safely?

Yes_____ No_____ If Yes; list and indicate necessary and reasonable accommodations to permit the student to perform clinical duties.

_____

Does the student have restrictions or limitations in performing their clinical duties safely?

Yes_____ No_____ If Yes; list and indicate necessary and reasonable accommodations to permit the student to perform clinical duties.

_____

Physician Signature: _____ Date: _____

Health Care Provider Stamp