INDIAN RIVER STATE COLLEGE
HEALTH SCIENCE DIVISION

This record becomes College property. Students must make personal copies prior to submission; copies will not be provided once submitted. Note: This information may be shared with clinical agencies.

Physical Examination

Health Science Program (Select One)

[illegible]

TO BE COMPLETED BY STUDENT BEFORE EXAMINATION

Last Name	First	Middle	(Area Code) Home Phone	Birth Date
Street Address	Apt	City	State	Zip Code

Emergency Contact ____

Name (Relationship to student) (Area Code) Phone Number

I understand that I may be asked to submit additional data. I understand that any falsification or omission of information can result in my dismissal from the health science program.

Student's Signature	Date	Student I.D. #

TO BE COMPLETED BY EXAMINER

Systems Reviewed	Normal Findings	
Blood Pressure	☐ Yes	☐ No
Temp	☐ Yes	☐ No
Height	☐ Yes	☐ No
Weight	☐ Yes	☐ No
Vision	☐ Yes	☐ No
Hearing	☐ Yes	☐ No
ENT	☐ Yes	☐ No
Respiratory	☐ Yes	☐ No
Cardiovascular	☐ Yes	☐ No
GI	☐ Yes	☐ No
GU/Reproductive	☐ Yes	☐ No
Neuro/Muscular	☐ Yes	☐ No
Endocrine	☐ Yes	☐ No
Integumentary	☐ Yes	☐ No

Do you consider this person to be physically and emotionally capable of performing the essential tasks required?

☐ Yes ☐ No

Examining Physician/Nurse Practitioner Signature

____

Date ____________________

PRINT

Practitioner/Facility Name and Address Phone: ( )