Colorado Christian
UNIVERSITY
College of Adult and Graduate Studies

STUDENT PHYSICAL EXAM FORM

Accountability Act of 1996 (HIPAA) Privacy Rule.

To be completed by a Healthcare Provider (*Physician, NP or PA*)

(Please Print and Submit)

Student Name_____ Birth date_____

Height_____ Weight_____ Pulse_____

Blood Pressure_____ Resp_____

Vision (Snellen) / R/L Corrected / R/L

Near Vision_____ Color Blindness _____

Hearing_____R_____L

Check if Abnormal:	Comments:
____General Appearance	_____
____Head & Scalp	_____
____Face & Skin	_____
____E.E.N.T.	_____
____Neck	_____
____Heart	_____
____Lungs	_____
____Breasts	_____
____Abdomen	_____
____Back & Spine	_____
____Extremities	_____
____Lymphatic	_____
____Neurological	_____
____Genitourinary	_____

Additional Comments:

_____

_____

_____

Name of Physician, NP, or PA (Please Print Clearly):_____

Address_____

Signature _____ **Date** _____

Upon admittance into the Nursing Program please return this form to:

myClinicalExchange

https://www.myclinicalexchange.com/Default.aspx

Information contained in this form will remain confidential and will not be disclosed without the written permission of the student, in compliance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

Colorado Christian UNIVERSITY
College of Adult and Graduate Studies

STUDENT PHYSICAL EXAM FORM

To be completed by the student applicant prior to the physical exam.

(Please Print and Submit)

NAME: _____

TELEPHONE: _____ MOBILE PHONE: _____

ADDRESS: _____

STREET CITY STATE ZIP

Injuries:

Hospitalization:

Other: (Check if condition applies to you)		Comments
Anemia	_____	_____
Arthritis	_____	_____
Asthma	_____	_____
Back or neck Injuries	_____	_____
Bladder/Bowel Problems	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Hearing Problems	_____	_____
Heart Disease	_____	_____
High B/P	_____	_____
Cognitive Disorder	_____	_____
Head Concussion	_____	_____
Seizures	_____	_____
Thyroid Disease	_____	_____
Ulcer (duodenal or stomach)	_____	_____
Visual Problems	_____	_____

MEDICATIONS YOU ARE PRESENTLY TAKING: _____

_____

ALLERGIES: Food _____ Drug _____ Latex _____ Other (please specify _____

PRESENT OR CHRONIC MEDICAL PROBLEMS: _____

_____

_____

I hereby affirm that the information provided on this form is correct.

Student Signature_____ **Date** _____

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