COLORADO CHRISTIAN UNIVERSITY
School *of* Nursing and Health Professions

STUDENT PHYSICAL EXAM FORM

Part I: To be completed by a Healthcare Provider

(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** _____

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.

Upon acceptance into the Nursing Program please submit this form to your CastleBranch account at https://www.castlebranch.com/.

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School *of* Nursing and Health Professions

STUDENT PHYSICAL EXAM FORM

Part II: To be completed by the Student

(Please Print and Submit)

Name: _____

Email: _____ Phone: _____

Address: _____

Street City Zip Code

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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