WAKE TECHNICAL COMMUNITY COLLEGE PHYSICAL EXAMINATION FORM

*To be completed and **signed** by a physician, PA, or nurse practitioner. All sections required. Please print in black or blue ink.*

TO BE COMPLETED BY THE STUDENT:

Last Name	First Name	Middle Name	Wake Tech Student ID#

Date of Birth (mo/day/year)	Major	Area Code/Phone Number

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

Height _____ Weight_____ BP _____/_____

Vision Screening

Corrected: Right 20/ _____Left 20/ _____

Uncorrected: Right 20/_____Left 20/ _____

Color Vision: ☐ Normal ☐ Abnormal *(please explain)*

_____

Hearing Screening

Gross/Overall Hearing:
☐ Normal ☐ Abnormal *(please explain)*

_____

15 ft. Whisper Test:
☐ Normal ☐ Abnormal *(please explain)*

_____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any paired organs? ☐Yes☐No
Explain _____

B. Is student under treatment for any medical or emotional condition?☐ Yes ☐ No
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) ☐Unlimited ☐Limited
Explain _____

D. Is student physically and emotionally healthy?☐ Yes ☐ No
Explain _____

E. **Based on my assessment of this student's physical and emotional health, he/she appears able to participate in the <u>activities of a health profession in a clinical setting</u>**. ☐ Yes ☐No If no, please explain.

Explain: _____

<u>CERTIFICATION REQUIRED:</u>

_____

Signature & Credentials of Physician/Physician Assistant/Nurse Practitioner **Date**

_____

PRINT Name & Credentials of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____

Name of Practice/Agency

_____

Office Address **City/State** **Zip Code**