WAKE TECHNICAL COMMUNITY COLLEGE - PHYSICAL EXAMINATION *(Please print in black or blue ink). To be completed and* ***signed*** *by a physician, physician's assistant or nurse practitioner. All sections required.*

This section 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

This section to be Completed by Healthcare Provider:

		/
Height	Weight	BP

Vision Screening				Hearing Screening		
				Gross/Overall Hearing:		
Corrected:	Right 20/		Left 20/		☐ Normal	☐ Abnormal *(please explain)*
Uncorrected:	Right 20/		Left 20/			
				15 ft. Whisper Test:		
Color Vision: ☐ Normal	☐ Abnormal *(please explain)*			☐ 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 (in a healthcare clinical setting)	☐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 activities of a health profession in a clinical setting.** ☐ Yes ☐No If no, please explain.		
	Explain		

CERTIFICATION REQUIRED		
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

I am submitting this completed Medical form and attest that it is true and complete to the best of my knowledge. I understand that if anything on this form changes while I am a student in the health program, I must notify the program director in writing within five (5) business days of the change.

Student Signature Student Name (Print) Date