AUGUSTANA UNIVERSITY NURSING PROGRAM
PHYSICAL EXAM FORM

This form is to be completed by a physician, nurse practitioner or physician's assistant within one year of starting the nursing clinical courses.

Student Name: _____ Date:_____

DIAGNOSES/HEALTH CONDITIONS:

Diagnosis/Condition	Treatment Plan

CURRENT MEDICATIONS (Prescription, OTC, herbal)**:**

Medication	Dose, Route, Frequency	Reason

ALLERGIES (Medication, Food, Environmental, Other)**:**

Allergen	Reaction

PHYSICAL EXAMINATION

Height (without shoes): _____ W**eight:** _____ **Blood Pressure:** _____ **Pulse:** _____

PHYSICAL EXAMINATION **(Please place a checkmark in the appropriate column)**	**Normal**	**Abnormal**	**Comments/Recommendations**
Head			
Eyes R-20/___, L-20/___ Correction			
Ears			
Nose and Sinuses			
Mouth/Teeth ( ) Fillings, ( ) Dentures			
Throat			
Neck/Thyroid			
Lungs			
Cardiovascular			
Abdomen			
Back/Spine			
Extremities			
Skin			
Neurologic			
Psychiatric (Behavior, Mood, Affect)			

CLEARANCE TO PARTICIPATE IN CLINICAL ROTATIONS:

□ Cleared to participate in clinical rotations without restriction
□ Cleared to participate in clinical rotations without restriction with recommendations for further evaluation or treatment of the following: _____
□ Not cleared for clinical rotations:
- □ Pending further evaluation for: _____
- □ Recommendations: _____

Signature of Health Professional Providing this Evaluation & Documentation: _____

Clinic Name & Address: _____

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