CHESTER CAREER COLLEGE

751 West Hundred Road
Chester, VA 23836
Phone: (804) 751-9191 FAX: (804) 751-2599

PHYSICIAN'S STATEMENT

Student's Name _____ Date _____

PHYSICIAL EXAMINATION

Height: _____ Weight: _____ T _____P_____R_____BP_____

Vision: Do you wear glasses or contact lens? _____Yes _____ No
Visual Acuity with corrective lenses: _____ R _____ L

Check if Normal:

Head	_____
Eyes	_____
Ears	_____
Nose/Throat	_____
Skin	_____
Lungs	_____
Heart	_____
Vascular	_____
Abdomen	_____
Genitalia	_____
Musculoskeletal	_____
Neurologic	_____

Laboratory Data:

	Test	Date	Results
Blood:	HgB	_____	_____
	Hct	_____	_____
Urine:	Glucose	_____	_____
	Protein	_____	_____
	Blood	_____	_____

Immunization Record: Record below dates received

DTaP or DT: _____
TDaP or TD: _____
Varicella: _____
Polio (OPV): _____
MMR: _____
Hepatitis B: _____
_____
_____

PPD
Date: _____
Results: _____

Chest X-Ray
Date: _____
Results: _____

Surg Tech (Addt'l Requirement)
Flu Vaccine: _____

To the best of your knowledge, are there any known medical (physical or psychological) conditions that may interfere with this student's ability to provide nursing care in either an acute or extended care setting?
_____ Yes _____ No - If yes, please explain below:
_____
_____

_____ _____
Date Signature of Examining Physician

_____
Address City State Zip Code