



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

PHYSICIAN'S STATEMENT

Student's Name _____ Date _____

PHYSICAL 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:

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

Immunization Record: Record below dates received

DTaP or DT: _____	PPD	Surg Tech (Add'l Requirement)
TDaP or TD: _____	Date: _____	Flu Vaccine: _____
Varicella: _____	Results: _____	
Polio (OPV): _____	Chest X-Ray	
MMR: _____	Date: _____	
Hepatitis B: _____	Results: _____	

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