Samford University
College of Health Sciences

Program of Study _____
SUID # _____

PHYSICAL EXAMINATION

_____ _____ **SEX:** M ____ F ____
LAST NAME **FIRST NAME** **MIDDLE** **BIRTH DATE**

All CHS students must submit a completed physical examination on this form prior to enrolling in courses. Please refer to your program/school handbook for further information on specific requirements.

Blood Pressure _____ Pulse _____ Height _____ Weight _____ lbs. Vision _____right _____left
_____

The College of Health Sciences (CHS) requires that all students have evidence of a physical examination from a physician, physician assistant, or nurse practitioner verifying that the individual is able to meet physical and mental requirements – with or without accommodation – for both didactic and clinical components of their respective program. The physical examination must be completed and this form submitted before the first day of class. The student affirms that by submitting this form he or she consents to the disclosure of the information contained herein to the program, school and college's administrators, faculty and staff, as well as experiential site preceptors/coordinators as is necessary to ensure compliance with program requirements and affiliated site requirements. Some programs may require an annual physical examination.

REVIEW OF SYSTEMS:
Are there abnormalities in the following systems? Describe fully, including any assistive devices which may be required (e.g. hearing aids, eyeglasses, prosthetics, etc.).

	NO	YES	Comments
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Neurologic			
Dermatologic			

ALLERGIES: _____

1. Is the patient now under treatment for any medical or psychological condition? NO_____ YES _____ (explain)
   _____
2. Does this patient have any active prescriptions, even if for occasional use only? NO_____ YES _____ (list)
   _____
3. Has this patient ever been diagnosed with alcoholism or another drug dependency (not including tobacco)? NO ____ YES ____ (list) _____
4. Are there any conditions, physical and /or psychological, which may interfere with functioning as a health professional student in the classroom or clinical setting? NO _____ YES _____ (please comment)
   _____

NOTES/COMMENTS:_____

Form must be completed by one of the following licensed healthcare providers: MD, DO, NP/CRNP, or PA. Nothing should be added to form after the healthcare provider signs and dates <u>UNLESS</u> the individual addition is signed, credentialed, and dated.

Licensed Healthcare Provider's Printed Name and Credentials: _____
Facility Name: _____
Facility Address: _____
City: _____ State: _____ Zip: _____
SIGNATURE OF PROVIDER: _____ DATE: _____