Care One Health Training Institute
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Fax: 919-773-7167

Medical / Physical Form
To Be Completed by A Health Care Provider

Name: _____Class: _____

Height: _____ Weight: _____ P _____ RR _____ BP _____

Eye / Vision: R _____ L _____

	Normal	Abnormal/Limitations*
Ears/Hearing		
Nose		
Mouth/Throat		
Teeth		
Neck		
Chest		
Heart		
Lungs		
Abdomen		
Back/Extremities		
Neurological		
Skin		
Able to lift at least50lbs		
Able to bend		
Able to stand for extended time		
Pregnant or not		

Final Report for the Physical

I have examined the above mentioned student on _____(date) and found him/her/they/them to be physically and mentally fit to perform the expected duties, such as, but not limited to; standing, bending, pulling, lifting patients, or equipment during labs or at a clinical setting.

Comments: _____

_____

_____

If applicable: PPD Date given _____ Date Read _____ Results _____

Date of chest X-ray (if applicable) _____

Facility Name and Address: _____

_____

Physician Name and Signature: _____

Date Physical was completed: _____

*It's the student's responsibility to notify the registrar immediately about any abnormal/limitations noted by the provider