Allied Health Physical Exam Form (to be filled out by the physician)

Last Name First Name Date of Birth

TO BE COMPLETED BY PHYSICIAN:

Temp: _____ Pulse: _____ Resp: _____ B/P: _____ Ht: _____ Wt: _____

General Appearance: _____

Skin: _____ Mucous Membranes: _____

Eyes: _____ Pupils: _____ Fundus: _____

Visual Acuity: _____ Color Vision: _____

Ears: _____ Hearing: _____ Nose: _____ Throat: _____

Chest: _____ Abdomen: _____

Heart: _____ Lungs: _____

Extremities: _____ ROM: _____

Lymph Nodes: Neck_____Axilla_____Inguinal_____Abdominal_____

Reflexes: _____

Check Box Below *OR* Specify Any Restrictions:

☐ ***I have found no evidence to indicate the student has any physical restrictions related to*** lifting (up to 50 lbs.), transferring (up to 100 lbs.), gait, bending/stooping/kneeling, standing (12 hrs.), reaching, manual dexterity, or balance ***or any health condition that would create a hazard to self, patients, or others.***

☐ ***Student has the following restrictions*:**

_____

_____

Restrictions are due to: _____

If restriction is related to pregnancy, estimated date of delivery is: _____

*Select Sign above to add your signature

Physician: _____ NPI Number: _____

Signature (required) (required)

_____ Date: _____

Type or Print Name (required)

Revised: 05/19/2020