



## HEALTH EXAMINATION FORM

LAST NAME: Lett FIRST NAME: Kristen TSCC ID #: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

THE FOLLOWING INFORMATION MUST BE COMPLETED BY A PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

|                                               |                  |              |          |                 |            |                                                                  |       |           |
|-----------------------------------------------|------------------|--------------|----------|-----------------|------------|------------------------------------------------------------------|-------|-----------|
| Allergies (Food/Drug/Latex, etc.) <u>NKDA</u> |                  |              |          |                 |            |                                                                  |       |           |
| C<br>O<br>M<br>P<br>L<br>E<br>T<br>E          | Height           | <u>62 in</u> | Weight   | <u>213 lbs.</u> | BP         | <u>136/79</u>                                                    | Pulse | <u>94</u> |
|                                               | Vision Right 20/ | <u>20</u>    | Left 20/ | <u>20</u>       | Corrected: | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |       |           |
|                                               |                  |              |          |                 |            |                                                                  |       |           |
|                                               |                  |              |          |                 |            |                                                                  |       |           |
|                                               |                  |              |          |                 |            |                                                                  |       |           |
|                                               |                  |              |          |                 |            |                                                                  |       |           |
|                                               |                  |              |          |                 |            |                                                                  |       |           |
|                                               |                  |              |          |                 |            |                                                                  |       |           |
|                                               |                  |              |          |                 |            |                                                                  |       |           |
|                                               |                  |              |          |                 |            |                                                                  |       |           |

The student has been diagnosed with a chronic/serious medical condition(s)? (Ex. Diabetes, hypertension, seizure disorders, etc.?) \_\_\_\_\_ Yes ☒ No

If yes, please list: \_\_\_\_\_

Is/are the condition(s) being presently controlled or treated? n/a Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

The student has been diagnosed with a psychiatric/mental condition(s)? (Ex. Bipolar, depression, chemical dependency, etc.) \_\_\_\_\_ Yes ☒ No

Is/are the condition(s) being presently controlled or treated? n/a Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

The student is taking prescribed medications on a regular basis? \_\_\_\_\_ Yes ☒ No

If yes, please list: none

On the basis of my examination on this day June 3, 2022, I approve the student's participation in Clinical Education.  
month, day, year

☒ Yes \_\_\_\_\_ No \_\_\_\_\_ Limited - If limited, please describe: \_\_\_\_\_

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Marcinda Fain, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain, CNP

Provider:  
Please place office stamp  
here (if possible) for  
validation purposes.

AUBURN UNIVERSITY MONTGOMERY  
STUDENT HEALTH CENTER  
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