



HEALTH EXAMINATION FORM

LAST NAME: Gulden FIRST NAME: Amanda TSCC ID #: _____ PHONE NUMBER: _____

DOB: 2/12/91

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

Allergies (Food/Drug/Latex, etc.)								
PCN								
C O M P L E T E	Height	<u>6'0"</u>	Weight	<u>149.3</u>	BP	<u>128/91</u>	Pulse	<u>83</u>
	Vision Right 20/	<u>20</u>	Left 20/	<u>20</u>	Corrected:	Y ☐ 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? 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? Yes ☒ No If yes, please describe: tx w/ Celexa

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

If yes, please list: Celexa 10mg once daily

On the basis of my examination on this day DEC 16, 2021, 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) Maranda Fain, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE M. Fain CRNP

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

AUBURN UNIVERSITY MONTGOMERY
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