



HEALTH EXAMINATION FORM

LAST NAME: OUTLAW FIRST NAME: Irene TSCC ID #: _____ PHONE NUMBER: (814) 746-7944

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

Allergies (Food/Drug/Latex, etc.) <u>NKDA</u>				
C O M P L E T E	Height <u>64</u>	Weight <u>195.2</u>	BP <u>137/85</u>	Pulse <u>75</u>
	Vision Right 20/ <u>25</u>	Left 20/ <u>25</u>	Corrected: ☒ ☐ NO	
		NORMAL	ABNORMAL FINDINGS	
	CBC	☒		
	Cardiovascular	☒		
	Pulses	☒		
	Heart	☒		
	Lungs	☒		
	Skin	☒		
	E.N.T.	☒		
	Gastrointestinal	☒		
	Musculoskeletal	☒		
	Neurological	☒		
	Other			

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: _____

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

If yes, please list: _____

On the basis of my examination on this day 1-5-2022, 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)

MARANDA FAIR CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

M. Fair CRNP

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