



HEALTH EXAMINATION FORM

LAST NAME: mitchell FIRST NAME: Breanna TSCC ID #: _____ PHONE NUMBER: _____

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

Allergies (Food/Drug/Latex, etc.) <u>NKA</u>								
C O M P L E T E	Height	<u>68 in</u>	Weight	<u>270.7 lbs</u>	BP	<u>138/84</u>	Pulse	<u>89</u>
	Vision Right 20/	<u>20</u>	Left 20/	<u>15</u>	Corrected:	<u>YES</u>	<u>NO</u>	

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 2.8.23, 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) Robin Blackwell
Wendy Barton, CRNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Robin Blackwell CRNP

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

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