



HEALTH EXAMINATION FORM

LAST NAME: Wood FIRST NAME: Kyla TSCC ID #: A00670989 PHONE NUMBER: 334 430 4895

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

Allergies (Food/Drug/Latex, etc.)								
C O M P L E T E	Height	<u>66</u>	Weight	<u>213.2</u>	BP	<u>126/78</u>	Pulse	<u>80</u>
	Vision Right 20'	<u>20</u>	Left 20'	<u>20</u>	Corrected:	☒ YES ☐ NO		

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 12/13/22 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) Lindsey T. Barton, CNP

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider: **AUBURN UNIVERSITY MONTGOMERY**
Please place office stamp
here (if possible) for
validation purposes. **STUDENT HEALTH CENTER**
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023