Physical Examination and Health History Form

Dear Healthcare Provider:

Students enrolled in health discipline majors may have encounters with individuals whose own health is compromised and those who may put the health of a student at risk. Thank you for your attention to the requirements when completing this form.

Healthcare Provider Information

(Please Print or Stamp)

Healthcare Provider's Name **Telephone**

Address **City** **State** **Zip**

PLEASE PROVIDE COMPLETE INFORMATION RELATED TO THE FOLLOWING QUESTIONS:

1 **Is the Student receiving medical care for any health condition(s) (this includes physical, psychological, mental or emotional conditions)?**

☐ No ☐ Yes

If Yes, Please Specify:

2 **Does the Student have any drug allergies?**

☐ No ☐ Yes

If yes, please specify (including environmental/food allergies):

3 **Latex Allergies?**

☐ No ☐ Yes

4 **Does the Student wear a Medical Alert Bracelet?**

☐ No ☐ Yes

If yes, please specify for what condition(s) the alert includes:

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Certification by Healthcare Provider

I certify that I have reviewed the health history and completed the physical examination of

Name of Student | Date of Exam

✓Check One: It is my medical opinion that this person

☐ ***Has no*** **current physiological, psychological, emotional/mental, or cognitive condition(s) that would disqualify him/her from participating in a classroom and/or clinical activities**

☐ ***Has limitations*** **that would affect his/her ability to participate in classroom and/or clinical activities.**

These limitations include:

_____

_____

_____

_____

_____

Signature of Healthcare Provider | Date

Student: Read and Sign

I have read the above findings and certify that it is complete and accurate and that I have fully disclosed any conditions that may interfere with my ability to perform safely and responsibly in the classroom and clinical environment while a student at Thomas Edison State University.

I understand it is my responsibility to keep all information, testing and immunizations up to date. Failure to do so will prevent participation in clinical activities. I agree to inform the clinical faculty of any health problems that may put my health or the health of others at risk while in the clinical area.

_____

Student's Signature | Date

_____

Print Name