Health Sciences and Human Services

PHYSICAL EXAM
BILL OF HEALTH

Please complete: Patient of Physical Exam/Bill of Health

Note to Student: Required forms should scanned by student and emailed to Dental Clinic DentalClinic@csi.edu

I have examined (student) _____ for_____
_____ admission on *Date:* _____
to a Health Sciences and Human Services program.

This individual meets the immunization requirements: Yes or NO
(*Circle - either a or b*)

a. Has no physical or psychological conditions that would disqualify him/her from participating in a Health Sciences and Human Services program or

b. Is currently undergoing adequate medical or psychological treatment for any such conditions. Treatment should not interfere with the educational experience.

_____ MD/NP/PAC _____ MD/NP/PAC
Print Name *Signature:*

_____ _____
Address:
Contact #:

Health Sciences and Human Services

PHYSICAL FORM

Student Name_____
Date_____

No.	System	Notes
1.	Skin, Lymphatics	
2.	Eyes	
3.	Ears	
4.	Nose, Throat	
5.	Neck, Thyroid	
6.	Breasts	
7.	Lungs	
8.	Heart Rate/Rhythm/Murmur	
9.	Abdomen	
10.	Extremities, Back, Spine	
11.	Neurological	
12.	Psychological	

Weight_____ Height _____ Temperature _____
Pulse _____ Respirations _____ Blood Pressure _____

The applicant: **should** _____ **should not** _____ have additional:
Medical _____ Psychological _____
Evaluation _____ Therapy _____

This individual **does** _____ **does not** _____ have a history, condition, or limitations that would *disqualify him/her* from participating in Health Sciences/Human Services Programs.

Notes:

_____ MD/NP/PAC _____ MD/NP/PAC
Type or Print Name *Signature*