TEXAS A&M INTERNATIONAL UNIVERSITY
COLLEGE OF NURSING AND HEALTH SCIENCES
DR. F.M. CANSECO SCHOOL OF NURSING

Signature of Supervisor and/or Faculty Member Date

Physical Examination Form

Name: **Student ID**:

Address: _____
Street **City** **State** **Zip Code**

Sex:_____ **DOB**: _____**Weight**: _____ **Height**: _____**B/P**:

Physical Examination	**No Limitations Noted**	**Other (Please describe)**
1. Past Medical History	U	
2. Eyes, Ears, Nose, Throat	U	
3. Heart	U	_____
4. Lungs/ Thorax	U	
5. Abdomen	U	_____
6. Extremities	U	_____
7. Spinal Column	U	
8. Neuro	U	_____
9. Skin	U	_____

I certify that I have examined this student and he/she is:

J In good health and is able to perform student nursing functions.

J Has the following restrictions: _____

_____
Date of Physical Examination Print Name of Physician

_____
Physician's Address Signature of Physician