Last Name (Please Print):_____First Name:_____Date of Birth:_____

This form must be completed and signed or stamped by a health care provider to be acceptable as proof of your physical exam information.

PHYSICAL EXAMINATION

	Limitations		Comments I Concerns:
HEENT I Vision I Hearing	YES	NO	
Cardiovascular I Respiratory	YES	NO	
Gastrointestinal	YES	NO	
Urological I Reproductive	YES	NO	
Musculoskeletal	YES	NO	
Neurological	YES	NO	
Mental Health Status	YES	NO	
Color Blindness: Will the student's inability to see color limit the ability to function in a hospital setting?	YES	NO	
Severe Latex Allergy: Does this student have a severe latex allergy?	YES	NO	
Overall: Does the student's health status permit UNRESTRICTED functional abilities essential to nursing practice?	YES	NO	

PHYSICIAN INFORMATION:	**APPLICANT/STUDENT SECTION:** I hereby authorize the release of my medical records to CastleBranchto meet the requirements set by my Richmond Higher Education Institution. I do this with the understanding that my personal information will not be disseminated for any other purpose than those specified by my educational institution. By affixing my signature, I grant full consent for the duration of my enrollment. I am aware that I can revoke my consent, in writing, at any time.
NAME: SIGNATURE: DATE: (Stamp Acceptable)	STUDENT SIGNATURE: