Hackensack Meridian *Health*
JFK Medical Center

Muhlenberg Harold B. and Dorothy A. Snyder
Schools of Nursing and Medical Imaging

PHYSICIAN PHYSICAL FORM

Student Name: _____

Date of Birth: _____ **Telephone (cell) #:** _____

Email Address: _____

Physician: _____ **Telephone #:**_____

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Blood Pressure: _____ Pulse: _____
Height: _____ Weight: _____

Vision: Does applicant wear glasses or contacts? Yes/No - Vision done with/without glasses
Vision: Far: OS: _____ OD: _____ OU: _____
Vision: Near: OS: _____ OD: _____ OU: _____
Vision: Far: OS: _____ OD: _____ OU: _____
Vision: Near: OS: _____ OD: _____ OU: _____

To Be Answered By Physician **Evidence of Past or Present Disease of Abnormality**	**YES/NO**	**EXPLAIN IF YES**
Teeth		
Skin		
Thyroid or other Endocrine Glands		
Lungs		
Abdominal Organs		
Hernia		
Musculoskeletal System		
Deformities		
Vascular System (Varicose Veins)		
Nervous System		
Reflexes		
Ears		

Heart

Location of apex beat: _____

Murmur: _____

Any other abnormality: _____

General Condition:

Good_____ Questionable: _____ Poor: _____

Clearance

____ I find the above-mentioned applicant in good health and approve him/her to participate in all physical clinical activities as a student in his/her curriculum.

____ I **DO NOT** approve this applicant to participate in the physical clinical activities as a student in his/her curriculum.

_____ _____
Physician Signature Date