Yuba College

Physical Evaluation

Date: _____ First Name: _____ Last Name: _____

Date of Birth: _____ Yuba College Email: _____ Phone: _____

HEALTH HISTORY - Check box items that apply.

☐Heart Disease ☐High Blood Pressure ☐Seizures/Epilepsy ☐Chest Pain ☐Diabetes ☐Bone, Joint Problems

☐Asthma ☐History of Concussion or Head Injury ☐Visual Problems/Blindness ☐Hearing Loss

☐Emotional/Psychiatric/Behavioral ☐Back Problems ☐Kidney Problems ☐Lung Problems/Shortness of Breath

ASSESSMENT - WNL = With Normal Limits (mark the box)

Height _____ Weight ____ Blood Pressure ____

☐Vision ☐Hearing ☐Oral Cavity ☐Neck ☐ Extremities ☐Cardiovascular ☐ Gastrointestinal ☐Genitourinary

☐Reflexes ☐Spine ☐Lift as least 20 pounds

Document any abnormal findings: _____

Medications (attach additional pages as needed)	Reason for use
Allergies (attach additional pages as needed)	Reaction

The student does not have any health condition that would create a hazard to themselves or others.

Student is able attend college and actively participate in clinical without any limitations.

Provider Printed Name/Title: _____

Provider Signature: _____ Date: _____

Provider Number: _____

Clinical Facility Name/Address: _____

Provider signing this form will indicate if there are any limitations to college and/or clinical participation (below) :

_____

_____

*Student- if you have any limitations make an appointment to see the Nursing, Allied Health Director

5/2/2022