Hackensack Meridian
JFK University 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

REVISED 5/30/22