SCHOOL OF NURSING
UNIVERSITY OF MICHIGAN

Office of Practice and Professional Graduate Program
PHONE: 734-763-7304
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# PHYSICAL EXAMINATION FORM

**TO BE FILLED OUT BY THE STUDENT**

| First Name | Last Name | UM ID | |
|---|---|---|---|
| Uniqname | Phone Number | DOB | Sex |
| Address | City | State | Zip |

**TO BE FILLED OUT BY THE HEALTHCARE PROVIDER**

| Temperature | Pulse | Respiratory Rate | Blood Pressure |
|---|---|---|---|

| EXAMINATION | NORMAL | ABNORMAL | COMMENTS |
|---|---|---|---|
| Head, Neck, and Thyroid | | | |
| Nose and Sinuses | | | |
| Mouth, Throat, Teeth, and Gums | | | |
| Eyes | | | |
| Ears | | | |
| Skin | | | |
| Chest and Lungs | | | |
| Heart and Vascular System | | | |
| Gastrointestinal System and Abdomen | | | |
| Musculoskeletal System and Extremities | | | |
| Neurological | | | |
| Mental Health | | | |

**I have given the student a complete physical examination. I feel that he/she is physically and mentally capable of participating without hazard in clinical practice settings for the University of Michigan School of Nursing.**

Healthcare Provider's Name and Title (Please Print)

Healthcare Center/Facility

Healthcare Provider's Signature

Address, City, State, Zip

Date

Phone Number