City College of San Francisco / John Adams Campus

Vocational Nursing Program

Physical Examination and Immunization Report

Name of Health Care Provider: _____

Address: _____

Telephone#: _____

Name of Physician: _____ Telephone#: _____

3 K \ V L F L D Q ¶ V _____ Date: _____

3 K \ V L F L D Q ¶ V _____

PHYSICAL EXAMINATIO N:

Head: _____

Ears: _____ Hearing _____ Hearing Aid R _____ L _____

Eyes: _____ Visual Acuity R _____ L _____ With Glasses: R ____/____ L ____/____

Teeth _____ Throat: _____ Neck: _____

Chest _____ Breath sounds: _____ Heart Rate: _____ Murmurs: _____

Abdomen: _____ Blood Pressure: _____

Are there any current physical or mental health conditions W K D W Z R X O G L Q D Q \ Z D \ O L P L W perform clinical nursing care?

□ Yes □ No

If yes, please describe in detail: _____

_____

_____

What medications are currently prescribed for this applica nt? _____

_____

Note: All blank areas have to be completed in ink.