

**ARMSTRONG ATLANTIC STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
Health Report For Faculty And Students
Annual Physical Exam**

Name	Student ID #
Address	
<i>Date of Physical Exam</i> _____	<i>Name of Examiner</i> _____ <i>Please print or type</i>
I have examined _____ and find:	
1. <input type="checkbox"/> no evident health problems which could interfere with the performance of required clinical activities.	
2. * <input type="checkbox"/> the following health problem(s)/restriction(s) which may/may not interfere with his/her performance of required clinical activities	
3. * <input type="checkbox"/> significant health problem(s) which would interfere with his/her performance of required clinical activities.	
BP _____ Pulse _____ Resp _____ Temp _____	
Ht. _____ Wt. _____ Hgb _____ U/A _____	
PPD Date _____ Results/Size _____ (Must be completed annually)	
<i>If PPD is positive, statement from physician or healthcare provider stating the recommended time for a follow-up will be needed (Attach Physician's Evaluation)</i>	
Date of Radiograph _____	
Was there Prophylaxis? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>If yes, what prophylaxis has been prescribed?</i>	
Signature of Health Care Provider	Street Address/City/State/Zip Code

(*Please explain #2 or #3 if checked and attach additional pages if necessary.)

RETURN TO: **Department of Nursing
Armstrong Atlantic State University
11935 Abercorn Street
Savannah, GA 31419-1997**