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Physical Ability Form

HEALTHCARE PROVIDER: I have performed a complete health examination on

(Print Student's Name)

General Medical:

Blood Pressure: Pulse:

Table with 6 columns: Exam Area, Normal, Abnormal, Exam Area, Normal, Abnormal. Rows include Head, Eyes, Ear, Nose, Throat, Neck, Skin, Respiratory, Heart, Abdomen, G/U, Other.

Physicians Comments:

OVERALL PHYSICAL EXAMINATION RESULTS:

Table with 3 columns: Results, Check One, Comments. Rows for PASSED WITHOUT LIMITATIONS, PASSED PENDING THE FOLLOWING, FAILED DUE TO THE FOLLOWING.

As of this date, I can find no physical or medical abnormality that would deter this student from fully participating and/or performing patient care activities in the clinical setting (extensive walking, bending, and lifting).

Signature of Nurse Practitioner, Physician Assistant, Medical Doctor, RN/LPN:

Date of Physical Examination: / /

Facility Name & Address

Provider Telephone Number: ()