



### PHYSICAL EXAMINATION FORM

**TO BE FILLED OUT BY THE STUDENT**

First Name	Last Name	UM UD	
Uniqname	Phone Number	DOB	Sex
Address	City	State	Zip

**TO BE FILLED OUT BY 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 Kinesiology IONM Program.**

_____ Healthcare Provider's Name and Title (Please Print)	_____ Healthcare Center/Facility
_____ Healthcare Provider's Signature	_____ Address, City, State, Zip
_____ Date	_____ Phone Number