

KIRKWOOD COMMUNITY COLLEGE

Student Health Physical & Clinical Clearance

STUDENT INFORMATION

Student Name:	Date of Birth:	K Number:
Program:	Phone:	Email:

PHYSICAL EXAMINATION - TO BE COMPLETED BY HEALTHCARE PROVIDER

Date of Examination:	Height:	Weight:	Blood Pressure:
Pulse:	Respirations:	Temperature:	Other:

Allergies: ☐ None ☐ Medication ☐ Food ☐ Latex ☐ Environmental ☐ Other:

Med-Alert Conditions / Significant Health Information:

CLINICAL EVALUATION

Please indicate the student's current health status in each area. Describe any restrictions, limitations, or concerns in the space provided.

Body System	No Restrictions	Restrictions / Concerns	Provider Comments
Neurological	☐		
EENT	☐		
Respiratory	☐		
Cardiac	☐		
Gastrointestinal	☐		
Immunological	☐		
Musculoskeletal	☐		
Psychological	☐		

HEALTH STATUS

Current Medications	
Past Surgeries / Hospitalizations	
Chronic Illnesses / Conditions	☐ None ☐ Cardiac ☐ Respiratory ☐ Diabetes ☐ Hypertension ☐ Seizure Disorder ☐ Cancer ☐ Musculoskeletal ☐ Anxiety ☐ Learning Disability ☐ Other:

CLINICAL PARTICIPATION CLEARANCE

Based on today's examination, is this student able to participate in the physical requirements of classroom, laboratory, and clinical activities?
☐ Yes, without restrictions ☐ Yes, with restrictions described below ☐ No
Restrictions / accommodations / additional comments:

HEALTHCARE PROVIDER CERTIFICATION

I certify that I have examined the student named above and have documented any health concerns or restrictions relevant to participation in the program.

Provider Name / Credentials:	Signature:
Clinic / Facility:	Date:

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