

## **Department of Nursing**

## Annual Physical Examination (To be completed by a licensed Healthcare Provider)

Student's Name:				To	Today's Date:		
Height:	Weight: _		B.P.:	P	ılse:	Temp:	
Visual Acuity:	O.D	C	orrected:	O	.S	Corrected:	
SYSTEM		Normal	Abnormal	Remarks (Descri	he Abnorma	lities)	
Skin		110111111	Tabliot illus	remarks (Desert		incres)	
HEENT							
Hearing							
Thorax & Lungs							
Heart & Vascular							
Lymphatics							
Abdomen							
Genitourinary							
Musculoskeletal/Spin	ne						
Neurologic							
Mental/Emotional							
litional Comments:							
Provider Name:				License #	:	State:	
Signature:				Agency N	Agency Name:		
Agency Address:				Agency I	Agency Phone #:		

California State University, Bakersfield 9001 Stockdale Hwy. • Bakersfield, CA 93311