PHYSICAL EXAMINATION
To be completed by Healthcare Provider
(Physician, Physician Assistant or Nurse Practitioner)

STUDENT NAME: ___________________________ STUDENT ID _______________________

PROGRAM: _______________________________________________________________________

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Temperature</th>
<th>Pulse</th>
<th>B/P</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
</table>

Pertinent Physical Findings:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Identify any health accommodations that will be necessary to function within the health care setting:
_____________________________________________________________________________________

Medication: _______________________________________________________________________

Physical/Emotional Limitations: _______________________________________________________

REMARKS AND RECOMMENDATIONS
___________________________________________________
_____________________________________________________________________________________

On the basis of my findings, I feel that this applicant is mentally and physically fit to enter a healthcare program and is able to work with no restrictions. This applicant is free of communicable diseases and capable of full participation in the health care profession.

Health Care Provider Signature: ___________________________ Date ____________________

Health Care Provider Printed Name: ___________________________________________________

Health Care Provider Contact Information: ____________________________________________

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