HEALTH APPRAISAL FORM

Height:  Weight:  BMI:  BP:  HR:  T:  O2 Sat:

Color Vision:  Snellen:

Body Habitus
Skin
Ears
Eyes
Neck
Neurological (CN II-XII)
Heart
Lungs
Abdomen
Inguinal Hernia (male only)
Low back
Posture
Extremities
Joints

Is there any defect of vision or hearing for which the school could compensate for by proper seating or other action? .............

Is there any physical defect which may limit participation in:
  a. Classroom activities?..............................................
  b. Clinical experience?..............................................
  c. Heavy lifting?.......................................................  

Is this student subject to any condition that may result in a classroom Emergency?.............................................................

Do you have knowledge of any emotional, mental or physical conditions for which this student should remain under periodic medical observation or is taking any type of medication for this condition?..............................................................

Nurse Practitioner Signature  Nurse Practitioner Name -- Print  License Number  Date

City College of San Francisco Student Health Services

50 Frida Kahlo Way, HC 100, San Francisco, CA 94112  415-239-3110  Fax: 415-239-3193

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