

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_



**Certificate of Health Statement  
Physical Exam**

**STUDENT:** Two Weeks before Start of Semester, upload this document to the Student Wellness Portal after having it completed by a physician with all supporting documentation. Link: <https://tompkincortland.studenthealthportal.com>; you will need Student ID # and Email for New Registrants. Alternatively, mail to: TC3 Health Services, Tompkins Cortland Community College, 170 North St, PO Box 139, Dryden NY, 13053-0139. Or fax to: 607-844-6533, print clearly on the fax cover sheet: Student’s Name, DOB, and “Nursing Student.”

**TO BE COMPLETED BY PHYSICIAN:**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_ / \_\_\_\_ Pulse \_\_\_\_\_ Temperature \_\_\_\_\_

Gross Vision OD \_\_\_\_\_ OS \_\_\_\_\_

Gross Hearing Right Ear \_\_\_\_\_ Left Ear \_\_\_\_\_

*Note to Physician: Clinical Evaluation - Check each item in appropriate column, “NE” is not evaluated*

Attribute	Normal	Abnormal	NE	Notes: (describe abnormal)
Head, Face, Neck, Scalp				
Nose				
Mouth, Tongue, Throat				
Ears, General				
Eyes				
Lungs and Chest				

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Heart (thrust, size, sounds, rhythm)				
Vascular (varicosities)				
Abdomen and Viscera (hernia)				
Endocrine - Thyroid				
Genitourinary				
Upper Extremities				
Lower Extremities				
Spine, Musculoskeletal				
Skin, Lymphatic				
Neurological				

In your assessment, is this patient mentally, physically and emotionally ready for the emotional and physical rigors for college nursing curriculum? If not, please explain your answer on separate paper and attach to form.

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Physician Signature \_\_\_\_\_

Date \_\_\_\_\_ Physician Stamp: