Health Certificate

Enrolling in: Fall ☐ or Spring ☐ 20_____

Please schedule a routine physical examination and submit this form to your physician to complete and return to Northpoint.

Name (First, Middle, Last) _____ Date of Exam _____

Address _____

Age _____ Date of Birth ____/____/_____ Height _____ Weight _____

Vital Signs: T_____ P_____ R_____ B/P_____

General Appearance: _____

_____

Skin: _____ Head: _____

Ears: _____ Eyes: _____

Visual Acuity (Without Glasses) R 20/_____ L 20/_____
(With Glasses) R 20/_____ L 20/_____

Oral Cavity: _____ Nose and Sinuses: _____

Neck: _____ Lymph Nodes: _____

Spine: _____ Heart: _____

Abdomen: _____ Chest and Lungs: _____

_____ _____

Upper Extremities: _____ Lower Extremities: _____

_____ _____

Urinalysis: _____ CBC: _____

Allergies: _____
(Include Rx)

Therapy: (Rx for Existing Ailments) _____
(Medication, Dosage, Frequency - Please Print)

Hx of Contagious Diseases: _____

Is the applicant able to attend college?

Yes
Yes, with restrictions: Please comment on reverse side.
No: Please comment on reverse side.

Physician's Name: _____
(Please Print or Type)

Physician's Signature: _____

Office Address: _____

Office Telephone Number: (____)_____

NORTHPOINT BIBLE COLLEGE GRAND RAPIDS

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