Crossing Rivers Health
Your bridge to wellness

Crossing Rivers Health Volunteer Health Screen

Date:_____ Time:_____ Provider: _____NP, DO, MD

Name:_____ DOB:_____

Physical Exam	Normal	Abnormal Findings…
Eyes		
Ears		
Nose		
Mouth/Throat		
Neck		
Chest		
Lungs		
Heart		
Abdomen		
Extremities		
Back		
Nervous System		
Other:		

I _____(patient/Volunteer) certify that I have been honest with my responses to the questions above.

I _____(provider) certify that based on my examination:

1). This individual appears symptom free of illness or communicable disease that may be transmitted through normal contact.

2). This individual appears to be physically able to work with adults and/or children.

Provider Signature_____NP, DO, MD Date_____