Name: ______________________________ **Sex: M** _______ **F** _______ **DOB:** ____________________

Date Submitted: ______________________________ (*Month, Day, Year*)

PHYSICAL EXAMINATION

THIS SIDE IS TO BE COMPLETED BY A PHYSICIAN, PHYSICIAN'S ASSISTANT, OR NURSE PRACTITIONER. TO AVOID DELAY IN THIS STUDENT'S MATRICULATION, PLEASE GIVE AS COMPLETE AND DETAILED INFORMATION AS POSSIBLE. PLEASE LEAVE NO BLANK SPACES. THE WORD "NORMAL" WRITTEN ACROSS THE PAGE AND A LINE DRAWN THROUGH A SPACE OR MULTIPLE SPACES IS NOT ACCEPTABLE.

Height _______ inches Weight _______ lbs. BP _________ Pulse _______ Vision R 20/ _______ L 20/ ______

HEAD/SCALP: ______________________________

EYES (Pupils, EOM's, Fundi): ______________________________

NOSE/THROAT: ______________________________

TONSILS: Present ______________ Removed ____________

EARS: ______________________________

HEARING: R __________________ L __________________

LUNGS: ______________________________

NECK: _________________ THYROID: ________________

CHEST: ______________________________

HEART: ______________________________

ABDOMEN: ______________________________

SPINE: ______________________________

EXTREMITIES: ______________________________

NEUROLOGICAL: ______________________________

JOINTS/MOBILITY: ______________________________

Are there any conditions of which we should be aware? Please describe fully. Use additional sheet if necessary. _______________

____

Is there loss or impairment of any paired organ? __No __Yes (explain)______________________________

____

Is this student now under treatment for any medical or emotional condition? __No __Yes (explain)__________________

____

Name, address, phone number of mental health professional (if applicable)______________________________

____

Is the student currently taking any medications? __No __Yes Please list, indicating purpose, dose, and instructions.________

____

Is any follow-up by the college Health Center staff indicated? ______________________________

____

Comments:____

Recommendations for physical activity (intramural, etc.) __Unlimited __ Limited Define activities allowed or not allowed.

____

Examiner's Signature ______________________________ Date of exam ______________________________

Print Last Name ______________________________ Phone #______________________________
(include area code)

Address ____
Street City State Zip Country

Updated 5/18