

PHYSICAL EXAMINATION*(Please print in black ink) To be completed and signed by physician or clinic*

A physical examination is required by **some schools and/or programs** (consult your college or department for specific requirements). If required, it must be completed in black ink and signed by a physician or clinic.

Last Name	First Name	Middle Name	Date of birth (Mo/day/year)	*Social Security Number
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Permanent Address	City	State	Zip Code	Area Code / Phone Number
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Height _____ Weight _____ TPR _____/_____/_____ BP _____/_____

IF REQUIRED: <u>Vision:</u> Corrected Right 20/ _____ Left 20/ _____ Uncorrected Right 20/ _____ Left 20/ _____ Color Vision _____ <u>Hearing:</u> (gross) Right _____ Left _____ 15 ft. Right _____ Left _____	IF REQUIRED: <u>Urinalysis:</u> Sugar: _____ Albumin _____ Micro _____ <u>Hgb or Hct</u> (if indicated) _____ <u>STS</u> (may be required by some departments) Date _____ Results _____ Recommendations _____
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Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

- A. Is there loss or seriously impaired function of any paired organs? Yes _____ No _____
 Explain _____
- B. Is student under treatment for any medical or emotional condition? Yes _____ No _____
 Explain _____
- C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
 Explain _____
- D. Is student physically and emotionally healthy? Yes _____ No _____
 Explain _____

* Only for Student Admitted to a **HEALTH SCIENCES PROGRAM** *

Based on my assessment of this student's physical and emotional health on _____, he/sh appears able to participate in the activities of a health profession in a clinical setting. Yes ____ No ____ If no, please explain _____
 (Date)

Signature of Physician/Physician Assistant/Nurse Practitioner

Date

Print Name of Physician/Physician Assistant/Nurse Practitioner

Area Code/Phone Number

Office Address

City

State

Zip Code

* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.