PHYSICAL EXAMINATION

A physical examination is required. This form must be completed in black ink and signed by a Physician, Nurse Practitioner or Physician Assistant.
Provider, please take a moment to counsel the future college student on lifestyle and social issues associated with the college experience.

Last Name First Name Middle Name	DOB (mo/day/yr)	Sex	Banner ID #

Permanent Address City State Zip Code	Area Code Phone #

Height ___________ Weight ___________ TPR ________/________/_________ BP ______________/______________

Vision: Corrected Right 20/_____ Left 20/_____
Uncorrected Right 20/_____ Left 20/

Color vision, if required ____________________________

Hearing: (gross) Right ________ Left ________
(15ft.) Right ________ Left ________

Urinalysis: Sugar ___________ Albumin _________________
Micro, if indicated ________________________

Hgb or Hct ____

Please note immunization requirements listed on page 3. Chest x-ray is required if PPD is not given or if PPD is >5mm for recent household contact of known case or if >10mm otherwise.

	NORMAL	ABNORMAL	NOT DONE	EXPLAIN ABNORMALITIES
General Appearance				
Head, Ears, Nose, Throat, Neck				
Eyes				
Respiratory				
Cardiovascular				
Mammary				
Gastrointestinal				
Hernia				
Genitourinary				
Musculoskeletal				
Metabolic / Endocrine				
Neuropsychiatric				
Skin				

A. Is there loss or seriously impaired function of any organs? No __________ If yes __________
Explain ____

B. Is student under treatment for any medical or emotional condition? No __________ If yes __________
Explain ____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ If limited ___________
Specify limitations ____

D. Is student physically, mentally and emotionally healthy? Yes __________ If no ___________
Explain ____

Only for Student Admitted to a Health Sciences Program

Based on my assessment of the student's physical and emotional/mental health on __________________, he/she appears able to participate in the activities of a health professional in a clinical setting. Yes __________ If no, explain ____________________

____

Signature of Physician, Nurse Practitioner, or Physician Assistant **Date**

Print Name of the above Examiner **(Area Code) Phone Number** **Fax Number**

Office Address **City** **State** **Zip Code**