Physical Form

TO BE FILLED OUT BY HEALTHCARE PROVIDER

Name____ Date of Exam___________________________

Height_____________ Weight________________ BP________________ Pulse ___________________

Vision: Right Left
20/_______ 20/________

TB Test Date Done ________________________
Date Read _________________________
Results ___________________________

Clinical Evaluation	Normal	Abnormal
1. Head		
2. Nose and Sinuses		
3. Mouth		
4. Ears		
5. Eyes		
6. Throat		
7. Lungs		
8. Heart		
9. Abdomen and Viscera		
10. Upper extremity		
11. Lower Extremity		
12. Musculoskeletal		
13. Skin		
14. Neurological		

Physician Comments:

Surgical procedures done within past 2 years:

Limitations/Rehabilitation needs:

Is the student under any treatment for any medical or emotional conditions? Yes______ No_______

Is the student allergic to any medications? If yes, please list: Yes______ No________

List: ____

Upon completion of a complete physical I have found ____
Student's Name

capable of participating in a full program of college study, including participation in intercollegiate sports and/or clinical activities.

Healthcare Provider Signature_____________________________________ Date______________________

Healthcare Provider Name____ Date______________________

Address____ Phone Number_____________________