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

Permanent Address	City	State	Zip Code	Area Code/Phone Number

Height _____ Weight_____ TPR _____/_____/_____ BP _____/_____

IF REQUIRED:

Vision: Corrected Right 20/ _____ Left 20/ _____

Uncorrected Right 20/ _____ Left 20/ _____

Color Vision _____

Hearing: (gross) Right _____ Left _____

15 ft. Right _____ Left _____

IF REQUIRED:

Urinalysis: Sugar:_____ Albumin _____

Micro _____

Hgb or Hct (if indicated) _____

STS (may be required by some departments)

Date _____ Results _____

Recommendations _____

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 Students Admitted to a **HEALTH SCIENCES PROGRAM** •

Based on my assessment of this student's physical and emotional health on _____ (Date), he/she appears able to participate in the activities of a health profession in a clinical setting. Yes_____ No_____ if no, please explain _____

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.

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IMMUNIZATION RECORD

(Please print in black ink) To be completed and signed by physician or clinic
A complete immunization record from a physician or clinic may be attached to this form.

Last Name	First Name	Middle Name	Date of Birth (mo./day/year)	*Social Security Number

SECTION A REQUIRED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year	mo./day/year
• DTP or Td	(#1)	(#2)	(#3)	(#4)
• Td Booster				
• Polio				
• MMR (after first birthday)				
• MR (after first birthday)				
• Measles (after first birthday)			**Disease Date	****Titer Date & Result
• Mumps			***(Disease Date NOT Accepted)	****Titer Date & Result
• Rubella			***(Disease Date NOT Accepted)	****Titer Date & Result

SECTION B RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

	mo./day/year	mo./day/year	mo./day/year	
• Hepatitis B series				****Titer Date & Result
• Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
• Meningococcal				
• Tuberculin (PPD) Test Date read				
(within 12 months) mm induration				
Chest x-ray, if positive PPD Date				
Results				
Treatment, if applicable Date				

SECTION C OPTIONAL IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year
• Haemophilus influenzae type b			
• Pneumococcal			
• Hepatitis A series			
• Typhoid (specify type)			
• Other			

Signature or Clinic Stamp REQUIRED:

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** _____

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** Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

*** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from physician, is not acceptable.

**** Attach lab report.

Do Not Write in This Space