



**Student Health Services**  
 Student Faculty Center, Lower Basement Rm.43  
 3340 North Broad Street  
 Philadelphia, PA 19140

**FALL 2022**  
 Phone: (215) 707-4088  
 Fax: (215) 707-2708  
 Web: <https://studenthealth.temple.edu/>

**PHYSICAL FORM**

**(CIRCLE NAME OF SCHOOL)**

**DENTAL** COLLEGE OF PUBLIC HEALTH: \_\_\_\_\_  
 (Name of Department)

**MEDICINE PHARMACY PHYSICIAN ASSISTANT PODIATRY**

NAME: \_\_\_\_\_  
 LAST FIRST

TU ID#: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**TO THE EXAMINING HEALTHCARE PROVIDER: Please review the student’s health data and complete this form. The information supplied will be used as a background for providing any necessary health care, and for identifying any need for accommodation to facilitate the student’s academic success. This information will be handled in accordance with all applicable law.**

Date of exam: \_\_\_\_\_ BP: R \_\_\_\_\_ L \_\_\_\_\_ PULSE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
 Normal Abnormal Remarks

	Normal	Abnormal	Remarks
General Health			
Skin			
Ears			
Eyes			
Neck (include thyroid exam)			
Lungs			
Heart			
Abdomen/hernia check			
Back			
Extremities			
Neurologic exam			

VISION: Uncorrected: OD \_\_\_\_\_ OS \_\_\_\_\_ Corrected: OD \_\_\_\_\_ OS \_\_\_\_\_

This Student is able to participate in all educational, physical and patient care activities: \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If No, please indicate what restrictions, accommodations, or modifications, if any, will be required for this student.

\_\_\_\_\_

Medical Summary: Note problems or suggestions for care:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Health Care Provider (please print): Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **MD/DO/CRNP** **Date:** \_\_\_\_\_