

Student Health Services

Student Faculty Center, Suite 322 3340 North Broad Street Philadelphia, PA 19140 Phone: (215) 707-4088 Fax: (215) 707-2708

Web: http://studenthealth.temple.edu

PHYSICAL FORM

(CIRCLE NAME OF SCHOOL) DENTAL **MEDICINE PHARMACY** PHYSICIAN ASSISTANT **PODIATRY** COLLEGE OF PUBLIC HEALTH: (Name of Department) NAME: __ 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: ____/_ PULSE: HEIGHT: WEIGHT: Normal Abnormal Remarks General Health Skin Ears Eyes Neck (include thyroid exam) Lungs Heart Abdomen/hernia check Back Extremities Neurologic exam OS _____ VISION: Uncorrected / Corrected: OD _____ OU This Student can participate in all educational, physical, and patient care activities: Yes If No, please indicate what restrictions, accommodations, or modifications, if any, will be required for this student.

Medical Summary: Note problems o	r suggestions for care:	
Health Care Provider (please print): Name:	
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Address:		
Address:	State:	 Zip: