TEMPLE UNIVERSITY®

**Student Health Services**
1700 N. Broad Street, 4th floor
Philadelphia, PA 19121-6262

Phone: (215) 204-7500
Fax: (215) 204-4660
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: _____
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: _____/_____ PULSE: _____ HEIGHT: _____ WEIGHT: _____

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

VISION: Uncorrected / Corrected: OD _____ OS _____ OU_____

This Student can 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:** _____