TEMPLE UNIVERSITY
A Commonwealth University

Student Health Services
Health Science Center
Student Faculty Center,
3340 N. Broad St.
Philadelphia, Pa. 19140
Tel: (215) 707-4088
Fax: (215) 707-2708

PHYSICAL FORM

(CIRCLE NAME OF SCHOOL)

DENTAL COLLEGE OF HEALTH PROFESSIONS

MEDICINE PODIATRY PHARMACY

NAME:_____
LAST FIRST
SS#_____

DOB:_____/_____/_____

TO THE EXAMINING HEALTHCARE PROVIDER: Please review the student's attached health data and complete this form. The information supplied will be used as a background for providing health care, if this is necessary; 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: _____

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

Vision: Uncorrected 0D _____ OS _____ Corrected: OD _____ OS _____

This Student is able to participate in all educational, physical and patient care activities: _____Y _____ N
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: _____ Zipcode: _____
Signature: _____ MD/DO/CRNP Date: _____