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

FALL 2011
Phone: (215) 707-4088
Fax: (215) 707-2708
Web: http://www.temple.edu/StudentHealth

PHYSICAL FORM

(CIRCLE NAME OF SCHOOL)

DENTAL **COLLEGE OF HEALTH PROFESSIONS:** ______________________________
(Name of Department)

MEDICINE **PHARMACY** **PODIATRY**

NAME:____
LAST FIRST

SSN#: ______________________________________

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: _________

	Normal	Abnormal	Remarks
General Health			
Skin			
Ears			
Eyes (include funduscopic exam)			
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:** ______________