



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

FALL 2009
 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:** _____