



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

FALL 2019
 Phone: (215) 204-7500
 Fax: (215) 204-4660
 Web: <http://www.temple.edu/StudentHealth>

PHYSICAL FORM

(CIRCLE NAME OF SCHOOL)

DENTAL COLLEGE OF PUBLIC HEALTH: _____
 (Name of Department)
 MEDICINE PHARMACY PODIATRY

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: R _____ L _____ 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: 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:** _____