Student Health Services
Student Faculty Center, Suite 322
3340 North Broad Street
Philadelphia, PA 19140

Phone: (215) 707-4088
Fax: (215) 707-2708
Web: http://studenthealth.temple.edu

PHYSICAL FORM

(CIRCLE NAME OF SCHOOL)

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

MEDICINE **PHARMACY** **PHYSICIAN ASSISTANT** **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:** ______________