TEMPLE UNIVERSITY®

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

Phone: (215) 204-7500
Fax: (215) 204-4660
Web: http://studenthealth.temple.edu

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:** _____