



Mercy College of Northwest Ohio Physical Form

Name: _____ Date of Birth ____/____/____

Address: _____ Social Security # ____/____/____

City: _____ State: _____ Zip: _____

(To be completed by a physician)

Temp: _____ Pulse: _____ Height: _____ Weight: _____

B.P. (Left) ____/____ (Right) ____/____ Cardio: _____

Eyes: (include Snellen) _____ Test for color blindness _____

Glasses: _____yes _____no Contacts: _____yes _____no

Ears: _____ Hearing: Left: _____ Right: _____ Nose: _____ Sinuses: _____

Skin: _____ Scars: _____ Throat: _____ Thyroid: _____

Adenoids/Tonsils: _____ Breasts: _____ Genitalia: _____

Peripheral Vascular: _____ Pulmonary: _____ Neurological _____

Abdomen: _____ Tenderness: _____ Palpable Masses: _____

Back: _____ Posture: _____

This student is fit for duty and free from communicable disease.

_____ ***Yes No If no, please describe.*** _____

Physician Signature: _____ Date: _____

Print Name: _____

Address: _____ Phone #: (____) _____