

PHYSICAL FORM

Student Name: _____ Program of Study: _____

Date of Birth: _____ / _____ / _____ Student SSN: _____
Month Day Year

Address: _____

City/State/Zip: _____

***** NOTE: Information below *MUST* be COMPLETED and SIGNED by a primary care practitioner (PCP) or physician. *****

Temp: _____ Pulse: _____ Height: _____' _____" Weight: _____ lbs
ft in

BP: 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: _____

Date of Office Visit: _____
Physician/PCP - Name (PRINTED) _____ Physician/PCP Signature: _____
Physician/PCP - Address: _____
Physician/PCP - City/State/Zip: _____
Physician/PCP - Phone Number: _____