

PHYSICAL EXAMINATION

(THIS SECTION TO BE COMPLETED BY YOUR PHYSICIAN OR NURSE PRACTITIONER)

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

Eye Examination Glasses: Yes No Contact Lenses: Yes No

Distant Vision: Right 20/_____ Corr. To 20/-_____
Left 20/_____ Corr. To 20/-_____

Normal	Abnormal	Notes on abnormality
_____ Skin	_____	
_____ Hearing	_____	
_____ Head	_____	
_____ Ear, Nose & Throat	_____	
_____ Neck: Thyroid	_____	
_____ Cardio-vascular	_____	
_____ Lungs	_____	
_____ Breasts	_____	
_____ Abdomen	_____	
_____ Rectum	_____	
_____ Genitalia	_____	
_____ Menstruation	_____	
_____ Back & Extremities	_____	
_____ Reflexes	_____	

Please note allergies or sensitivities which may be significant. _____

Is this student presently under medical therapy or psychological counseling?

Please explain any physical or emotional conditions which you consider important

Impression and Recommendations