TEMPLE UNIVERSITY®

Student Health Services
Student Faculty Center, Lower Basement Rm.43
3340 North Broad Street
Philadelphia, PA 19140

FALL 2014
Phone: (215) 707-4088
Fax: (215) 707-2708
http://www.temple.edu/StudentHealth

PHYSICAL FORM

(CIRCLE NAME OF SCHOOL)

DENTAL **COLLEGE OF HEALTH PROFESSIONS:** _____
(Name of Department)

MEDICINE **PHARMACY** **PODIATRY**

NAME:_____
LAST FIRST

SSN#: _____

DOB: _____/_____/_____

TO THE EXAMINING HEALTHCARE PROVIDER: Please review the student's attached health data and complete this form. The information supplied will be used as a background for providing health care, if this is necessary; 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 (include funduscopic exam)			
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:** _____