Student Name:_____ Date of Birth: _____

PROVIDENCE COLLEGE STUDENT HEALTH CENTER |(401) 865-2422
Personal and Confidential

PHYSICAL EXAM *Provider must fill out and sign below or supply EMR.*

Past Medical History: _____

Current Meds/Therapies: _____

Physical Limitations: _____

Blood Pressure:_____Pulse:_____Height:_____Weight: _____

VISION: DISTANCE R_____ L_____ BOTH _____

CORRECTED ◯ NOT CORRECTED ◯

GLASSES ◯

CONTACTS ◯

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
HEENT			BACK		
NODES			MS		
CV			NEURO		
RESP			SKIN		
ABD			GU/GYN		

Comments: _____

_____

SUMMARY OF EXAMINING PROVIDER

Is this student receiving or does he/she require continuing medical care, therapy or observation?
YES ◯ NO ◯ *If yes, please explain:*

_____

_____

On the basis of the foregoing Medical History and Physical Examination, should restrictions be imposed on physical activity?

YES ◯ NO ◯ *If yes, please explain:*

_____

_____

From the standpoint of physical and mental health, do you have any reservations about the advisability of this individual's plans for his/her college years? YES ◯ NO ◯ *If yes, please explain:*

_____

_____

Provider Name (*please print*): _____

Provider Signature (*required*): _____

Address: _____
Street City State Zip

Phone:_____

Fax: _____ Date of Exam: _____