WPI PHYSICAL EXAMINATION

Physical examination must be completed within 12 months prior to registration dateby a health provider who is not a parent of this student.
Required for all undergraduate students.

Student's Name:_____ **Date of exam:**_____ **Date of Birth:**_____

Height_____ Weight_____ BMI_____ BP_____ Pulse_____ Vision test: OD_____ OS_____ OU_____

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lymph nodes		
Thyroid		
Lungs / Chest		
Breasts		
Cardiovascular (murmurs)		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurological		
Psychological		
If any blood tests are done, please include a copy of the results.		

CURRENT AND CHRONIC PROBLEMS:

_____ _____

_____ _____

If the student is under care of a medical provider for a chronic condition or serious illness, please provide additional clinical reports to assist us in providing continuity of care. _____

_____

CURRENT MEDICATIONS (include Vitamins, Over the Counter Medications, Contraceptives, Inhalers and Epi-Pens):

_____

ALLERGIES _____ **Type of Reaction** _____

_____ _____

_____ _____

Has an Epi-pen been prescribed (please circle)? Yes or NO

T**uberculosis Risk** (please circle): Low Risk or High Risk (complete the Tuberculosis Screening Form for documentation of high risk students)

Physical Activity Clearance: Cleared Not Cleared Cleared with restrictions (please specify below)

_____

Health Care Provider Signature_____ **Date** _____

Health Care Provider (please print)_____ Date_____

How long have you known this patient? _____

Address_____

Phone _____ Fax _____