MEDICAL EXAMINATION FORM

DATE: _______________ SCHOOL YEAR: ________

ID NUMBER: ___________________ COLLEGE: _______________
LAST NAME: ___________________ FIRST NAME: ________________ M.I.: __________
CONTACT #: ___________________ CONTACT PERSON IN CASE OF EMERGENCY: _______________
RELATIONSHIP: _______________ CONTACT #: ___________________

AUTHORITY TO CONDUCT MEDICAL EXAMINATION

I, ____________________________, __________ years old accept and understand that I am required to undergo a physical examination and chest x-ray to determine my fitness and well-being as a student. I fully understand that the results will be held as confidential medical records and will be used by the University for my care and treatment. My health information cannot be released to third persons except with my consent or unless the disclosure of the information is required by law. I also accept and understand that the procedures are requirements for the next academic year enrolment. I acknowledge that my medical records will be retained by the University for a period of 5 years from examination or health visit.

_________________________ Signature of Student

PHEX Consultation Details

Physical Exam (to be filled-out by a nurse/doctor)

- Blood Type ________________
- Blood Pressure ________________
- Resp. Rate ________________
- Temperature ________________
- Pulse Rate ________________
- Height (in inches) ________________
- Weight (in pounds) ________________
- BMI (to be computed by the system) ________________
- BMI Category-system-generated ________________
- LMP (Female) ________________
- Right Vision ________________
- Left Vision ________________

- Corrective Lens

- MROTC ________________
- MPE ________________

Medical History (updated)

1. ________________
2. ________________
3. ________________
4. ________________

Medications ________________

Social History

- Smoking
- Drinking
- Exercising

Findings

- Extremities
  - Left Handed
  - Right Handed

Diagnosis

________________
________________
________________

Assigned Nurse

_________________________

Examining Physician

_________________________

Remarks/Recommendations

- Physically Fit
- For Clearance

- Physically Fit
- For Clearance