



AUTHORITY TO CONDUCT MEDICAL EXAMINATION

DATE: _____
SCHOOL YEAR: _____

ID NUMBER: _____ COLLEGE: _____
LAST NAME: _____ FIRST NAME: _____ M.I. _____
CONTACT#: _____ GENDER: ☐ FEMALE ☐ MALE
CONTACT PERSON IN CASE OF EMERGENCY: _____ RELATIONSHIP: _____
CONTACT#: _____

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.

PHEX Consultation Details

Physical Exam (to be filled up 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

Remarks/Recommendations

☐ Physically Fit
☐ For Clearance

Signature of Student

Physical Findings	Abnormal Findings
EENT ___ Normal	
Head and Neck ___ Normal	
Breast ___ Normal	
Lungs ___ Normal	
Heart ___ Normal	
Neurologic ___ Normal	
Chest X-ray ___ Normal	
Abdomen ___ Normal	
Skin ___ Normal	

Assigned Nurse

Examining Physician



Assigned Nurse

Examining Physician