Mail To: North Carolina A&T State University Student Health Center

1601 E. MARKET STREET GREENSBORO, NC 27411

**Form D**

**PHYSICAL EXAMINATION** ( Required For Special Group)

| Last Name | First Name | Middle Name | DOB (mo/day/yr) | Banner ID# |
|---|---|---|---|---|
| | | | | |

| Permanent Address | City | State | Zip Code | Area Code Phone # |
|---|---|---|---|---|
| | | | | |

Height _____ Weight _____ TPR ____/____/____ BP ____/____

Vision: Corrected Right 20/____ Left 20/____
Uncorrected Right 20/____ Left 20/____

Color vision, if required _____

Hearing: (gross) Right _____ Left _____
(15ft.) Right _____ Left _____

Urinalysis: Sugar _____ Albumin _____
Micro, if indicated _____

Hgb or Hct _____

STS (may be required by some departments)

Date _____ Results _____

Please note immunization requirements listed on page 3. Chest x-ray is required if PPD is not given or if PPD is >5mm for recent household contact of known case or if >10mm otherwise.

| | NORMAL | ABNORMAL | NOT DONE | EXPLAIN ABNORMALITIES |
|---|---|---|---|---|
| General Appearance | | | | |
| Head, Ears, Nose, Throat, Neck | | | | |
| Eyes | | | | |
| Respiratory | | | | |
| Cardiovascular | | | | |
| Mammary | | | | |
| Gastrointestinal | | | | |
| Hernia | | | | |
| Genitourinary | | | | |
| Musculoskeletal | | | | |
| Metabolic / Endocrine | | | | |
| Neuropsychiatric | | | | |
| Skin | | | | |

A. Is there loss or seriously impaired function of any organs? No _____ If yes _____
Explain _____

B. Is student under treatment for any medical or emotional condition? No _____ If yes _____
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited ____ If limited _____
Specify limitations _____

D. Is student physically, mentally and emotionally healthy? Yes _____ If no _____
Explain _____

**Only for Student Admitted to a Health Sciences Program**

Based on my assessment of the student's physical and emotional/mental health on _____, he/she appears able to participate in the activities of a health professional in a clinical setting. Yes _____ If no, explain _____

_____
**Signature of Physician, Nurse Practitioner, or Physician Assistant** **Date**

_____ _____ _____
**Print Name of the above Examiner** **(Area Code) Phone Number** **Fax Number**

_____ _____
**Office Address** **City** **State** **Zip Code**