



PHYSICAL EXAMINATION

TO BE COMPLETED BY A PHYSICIAN, PHYSICIAN'S ASSISTANT, OR NURSE PRACTITIONER. TO AVOID DELAY IN THIS STUDENT'S MATRICULATION, PLEASE GIVE AS COMPLETE AND DETAILED INFORMATION AS POSSIBLE. PLEASE LEAVE NO BLANK SPACES. THE WORD "NORMAL" WRITTEN ACROSS THE PAGE AND A LINE DRAWN THROUGH A SPACE OR MULTIPLE SPACES IS NOT ACCEPTABLE. The physical examination must be within one year prior to entrance date. Give your health care provider a stamped envelope addressed to: Health Center, Thomas College, 180 W. River Rd., Waterville, ME 04901. This can also be faxed to (207)859-1126 or emailed to healthctr@thomas.edu.

Name: _____ Sex: M_F _____ DOB: _____

Date Form Completed: _____ (Month, Day, Year)

Height _____ inches Weight _____ lbs. BP _____ Pulse _____ Vision R 20/ _____ L 20/ _____

HEAD/SCALP: _____ EYES (Pupils, EOM's, Fundi): _____

NOSE/THROAT: _____ TONSILS: Present _____ Removed _____

EARS: _____ HEARING: R _____ L _____

LUNGS: _____ NECK: _____ THYROID: _____

CHEST: _____ HEART: _____

ABDOMEN: _____ SPINE: _____

EXTREMITIES: _____ NEUROLOGICAL: _____

JOINTS/MOBILITY: _____

Are there any conditions of which we should be aware? Please describe fully. Use additional sheet if necessary. _____

Is there loss or impairment of any paired organ? No Yes (explain) _____

Is this student now under treatment for any medical or emotional condition? No Yes (explain) _____

Name, address, phone number of mental health professional (if applicable) _____

Is the student currently taking any medications? No Yes Please list, indicating purpose, dose, and instructions. _____

Is any follow-up by the college Health Center staff indicated? _____

Comments: _____

Recommendations for physical activity (intramural, etc.) Unlimited Limited Define activities allowed or not allowed. _____

Examiner's Signature _____

Date of exam _____

Print Last Name _____

Phone # _____
(include area code)

Address _____
Street City State Zip Country