



PHYSICAL EXAMINATION

This form is to be completed, signed by a health care provider (the physical must be within 1 year) and returned to Health Service by **July 15th (Fall Semester), January 1st (Spring Semester), or May 15th (Summer Semester)**. This information is confidential and is only used by the Health Service professional staff in assuring the student's health and for addressing special needs during his/her college experience. **A \$5 fee will be assessed if a form is returned late.**

Last Name _____ First Name _____ M.I. _____ Social Security # _____

Male _____ Female _____ Birth date (month/date/year) _____

Weight _____ Height _____ Blood Pressure _____ Pulse _____

Visual Acuity: R 20/ _____ Corrected - yes _____ no _____ Glasses - yes _____ no _____
 L 20/ _____ Corrected - yes _____ no _____ Contact Lenses - yes _____ no _____

History of drug allergy: _____

Allergies: _____

Are there any abnormalities of the following systems? Describe fully:

	Normal	Abnormal	Describe each abnormality
Eyes	_____	_____	_____
Head, ENT	_____	_____	_____
Respiratory	_____	_____	_____
Cardiovascular	_____	_____	_____
Lymphatic	_____	_____	_____
GI	_____	_____	_____
Hernia	_____	_____	_____
GU	_____	_____	_____
Musculoskeletal	_____	_____	_____
Metabolic/Endocrine	_____	_____	_____
Neurologic/Psychiatric	_____	_____	_____
Skin – Scars, tattoos, piercings	_____	_____	_____
Teeth, mouth	_____	_____	_____

Loss or seriously impaired function of any organ? Yes _____ No _____

History of emotional disorder? Yes _____ No _____ including: depression, suicide attempts, panic attacks, eating disorder, etc. If yes, please describe: _____

If yes, is student currently undergoing treatment and/or taking medication? Yes _____ No _____
 List all medications taken regularly including dosages. _____

History of drug/alcohol/tobacco abuse? Yes _____ No _____ if yes, please describe: _____

History of hospitalization or any surgery? _____

Describe fully with dates: _____

Is student cleared to participate in unrestricted rigorous competitive/noncompetitive sports events at Centenary College for the 2009 – 2010 academic year? Yes _____ No _____

Explain any condition or handicap that will prevent or limit the student's full participation in activities at Centenary College (especially if an Equine major, athlete or have special needs requiring a single room. If so, a separate letter should be attached to this form stating medical reason for single room accommodations). _____

Is the student now under treatment for any existing medical problems of which the College should be aware?

Examiner's signature: _____ Date _____
Examiner's name (print) _____

Address _____

Phone _____ Fax _____

Stamp

PLEASE RETURN TO:

Centenary College Health Service
400 Jefferson Street
Hackettstown, NJ 07840
Phone (908) 852-1400, ext. 2206
Fax (908) 979-4290