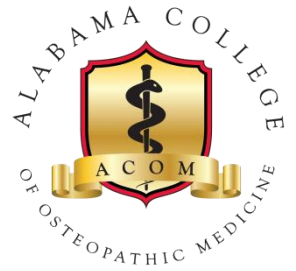


Physical Examination Form



Student Name: _____ Date of Birth: _____

SSN: _____ Height: _____ Weight: _____

BP: _____ Pulse: _____ Respiratory Rate: _____ Temperature: _____

General: _____

HEENT: _____

Neck: _____

Lungs: _____

Heart: _____

Abdomen: _____

Neurologic: _____

Extremities: _____

Skin: _____

Psychiatric: _____

Physicians Name: _____ Address: _____

Signature: _____

Date: _____ Phone No.: _____