

# DREW

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Month Day Year

**Required** for First-Year CLA students and Transfer students.

**Optional** for Grad/Theo/CUE students.

## PHYSICAL EXAMINATION

(To Be Completed by Health Care Provider)

**STUDENT:** Please attach completed Immunization Record for provider confirmation

**EXAMINER:** Complete this form and confirm the immunization record. This person has been accepted at Drew University. The information will not affect his/her status and will be used only as background for providing health care. With the exception of the immunization record, no part of this medical record will be disclosed or released without written client permission.

Please print clearly as this form will be scanned into the patient record by Drew University Health Services.

### MEDICAL EXAMINATION (Required within the past year and prior to the first day of class.)

Blood pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

VISION: Uncorrected: (Left) \_\_\_\_\_ (Right) \_\_\_\_\_ Corrected: (Left) \_\_\_\_\_ (Right) \_\_\_\_\_

### PHYSICAL EXAMINATION

NORMAL ABNORMAL FINDINGS

**Skin**

**HEENT**

**Neck**

**Cardiovascular**

**Lungs**

**Breasts**

**Abdominal**

**Genito-urinary**

**Musculo-skeletal**

**Neurological**

**Psychological**

**Skin**

The applicant \_\_\_ does \_\_\_ does not have a history of emotional, psychological or psychiatric disorder.

Please List any allergies including reaction:

Please List any current medications and associated problem:

Examiner's Comments/Recommendations:

Is student able to participate in rigorous physical activity? \_ Yes \_ No

HEALTH CARE PROVIDER NAME, ADDRESS AND SIGNATURE REQUIRED BY NJ STATE LAW				
Name		Telephone		Stamp:
Address		Fax		
Signature		Date		

**Instructions to student:** Please complete and mail all completed, signed documents together in one envelope to:

**DREW UNIVERSITY HEALTH SERVICES, 36 Madison Ave, Madison, NJ 09740.**