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.