University Health Center
Physician's Health Evaluation

Cairn UNIVERSITY | *Walk a Different Path*

ALL STUDENTS MUST HAVE THIS PHYSICAL FORM COMPLETED PRIOR TO ATTENDING CLASSES AT CAIRN UNIVERSITY.

TO THE EXAMINING PHYSICIAN: Please review the student's health history and complete this form. Please comment on all positive answers. The information you supply will not affect his or her status; it will be used only as a background for providing necessary health care. This information is strictly for the use of Cairn University's Health Center and Athletic Department and will not be released without student consent.

PLEASE PRINT

Student's Full Name:_____ Date of Birth:_____Sex: ☐ Male ☐ Female

Height:_____Inches Weight: _____Lbs. BP:_____/_____ Pulse:_____Pox:_____

Resp:_____Temp:_____

Vision Screening: Right 20/: _____ Left 20/: _____ **Uncorrected or Corrected**

Allergies:

Foods: _____ Medications: _____ Insect Stings: _____ Other: _____

Current Medications:_____

TB TEST - MANTOUX Test Date _____/_____/_____ **Date Read** _____/_____/_____ **Results** _____**mm**

OR IGRA Date _____/_____/_____ **Results** _____

Chest X-ray (IF INDICATED) Date _____/_____/_____ **Results** _____

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS?

	YES	NO		YES	NO		YES	NO
Head, Ears, Nose, or Throat	☐	☐	Hernia	☐	☐	Metabolic/Endocrine	☐	☐
Eyes	☐	☐	Genitourinary	☐	☐	Skin	☐	☐
Respiratory	☐	☐	Musculoskeletal	☐	☐	Is there loss or seriously		
Cardiovascular	☐	☐	Neuropsychiatric	☐	☐	impaired function of any		
Gastrointestinal	☐	☐	Lymphatics	☐	☐	paired organ?	☐	☐

If you answered yes to the above question, please describe fully:_____

_____

_____

Do you find any reasons which would make it medically inadvisable for the student to participate in supervised athletic activities? Yes No

If yes, please explain: _____

_____

Do you have any recommendation regarding the care of this student? Yes No

If yes, please explain: _____

Is the patient now under treatment for any medical or emotional condition? Yes No

If yes, please explain: _____

BY SIGNING THIS FORM, I HEREBY AFFIRM THAT THE INFORMATION CONTAINED HEREIN CONCERNS THE STUDENT LISTED ABOVE AND IS A TRUE ACCOUNT TO THE BEST OF MY KNOWLEDGE.

Physician's or Nurse Practitioner's Signature: _____

Name (please print):_____

Address:_____

Phone Number: _____ Date:_____

RETURN ALL INFORMATION TO: University Health Center, Cairn University, 200 Manor Avenue, Langhorne, PA 19047-2990

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