PHYSICAL EXAMINATION--HEALTH CERTIFICATE

(Must be completed by physician)

Applicant's Name: _____ Date: _____
Home Address: _____ Phone: _____
Height: _____ Weight: _____ Pulse: _____ B.P. High _____
Vision: R20/ ____ Corrected 20/ _____ Low _____
L20/ ____ Corrected 20/ _____ Normal _____

Previous Diseases (Please Check):	**Past (Date)**	**Current**	**Comments**
Asthma			
Allergies			
Bronchitis			
Diabetes			
Epilepsy			
Heart Trouble			
Migraine			
Rheumatic Fever			
Ulcers			
Have you ever been treated for or hospitalized for nervous or emotional condition?			
Other serious diseases or operations:			
	Normal	**Abnormal**	**Describe Abnormalities**
Eyes			
Ears			
Nose			
Throat			
Chest & Lungs			
Heart			
Abdomen			
Spine			
Extremities			
Lymphatics			
Neurological			

State any medicine or drugs to be used regularly by applicant: _____
_____

Any physical disability that will prevent student from participating in any form of physical activities or duties?
_____

In your opinion, is applicant adaptable to dormitory living? _____

Does applicant have any communicable disease that would prevent dormitory living? _____

Examiner: _____
Address: _____
DATE: _____

PLEASE INCLUDE A COPY OF ALL IMMUNIZATIONS ON FILE FOR THIS INDIVIDUAL

TO EXAMINING PHYSICIAN: Please mail this form to:

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