

**SOUTHERN WESLEYAN UNIVERSITY
PHYSICAL EXAMINATION FORM**

First page to be completed by the student prior to examination

Last Name, First Name, and Middle Name

Birth Date

Home Address

Sex M() F()

City, State, and Zip Code

Social Security No.

Insurance Information: (Copy of medical insurance card required)

Name of Health Insurance Company _____

Personal Coverage? Yes No (Circle One) Coverage under Parents? Yes No

Personal History to be completed by Parent or Student

Have you had	Yes	No		Yes	No		Yes	No
Frequent Anxiety			Pain/Pressure in Chest			Dizziness, Fainting		
Frequent Depression			Chronic Cough			Kidney Disease		
Worry or Nervousness			Palpitations (Heart)			Albumin/Sugar in Urine		
Recurrent Headaches			High or Low Blood Pres.			Frequent Urination		
Head injury with Unconsciousness			Rheumatic Fever			Ear, Nose, Or Throat Trouble		
			Weakness, Paralysis			Asthma		
Epilepsy, Convulsions			Disease or Injury of Joints			<u>Allergies:</u> <u>List</u>		
Hay Fever			Back Problems					
Tuberculosis			Tumor, Cancer					
Shortness of Breath			Jaundice					
Measles			Stomach or Intestinal Problems					
German Measles							<u>Females only</u>	
Mumps			Gallbladder Trouble			Irregular Period		
Chicken Pox			Recurrent Diarrhea			Severe Cramps		
Diabetes			Rupture, Hernia			Excessive Flow		
Eye Trouble			Recent Gain or Loss of Weight					

I permit (student name) _____ to be examined and treated by the Southern Wesleyan University physician and medical staff. – Signature _____ (Parent)

****Please complete if student is under 18 years old****

Emergency Contact Information (must be completed)

Contact #1 _____ Phone #1 _____ Phone #2 _____

Contact #2 _____ Phone #1 _____ Phone #2 _____

Reminder: Per the Policy and Procedures section of the Student Handbook, a completed medical form must be on file with the Southern Wesleyan University Health Center before the student will be permitted to attend classes.

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Immunization Information

Required Immunizations:

Recommended Immunizations:

MMR #1 _____ MMR#2 _____ Tetanus (within last 10 years) _____	Hepatitis B 1. _____ 2. _____ 3. _____ Hepatitis A _____ Meningitis _____ HPV (females only) _____
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Physical Examination to be completed by a Physician

<u>Urinalysis</u> Sugar _____ Albumin _____ Micro _____ Hemoglobin _____	<u>BP</u> _____/_____ Height _____ Weight _____	<u>Visual acuity</u> Right – 20/ ____ Left – 20/ ____
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Any abnormalities in the following systems? Describe fully.

	Yes	No	
Head, Ears, or Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Immune			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

List any recent surgery: _____

List any medical problems the student has had: _____

List any medications the student is now taking: _____

Is there loss or seriously impaired function of any organ? Yes or No

Do you have any general comments? _____

Recommendations for physical activity (P.E., Competitive Athletics, I.M.s)
 Limited _____ Unlimited _____ if limited, please explain: _____

Do you have any recommendations regarding the care of this student? _____

Is the student now under treatment for any medical or emotional condition?

No _____ Yes _____ (explain) _____

Signature of Physician	Phone Number	Date of Examination / /
Address	City, State and Zip Code	

Please return to the Health Center, Southern Wesleyan University, SWU Box 1874, PO Box 1020, Central, SC, 29630. Fax: 864-644-5973