

**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**

| <b>Have you had</b>              | <b>Yes</b> | <b>No</b> |                                | <b>Yes</b> | <b>No</b> |                               | <b>Yes</b>          | <b>No</b> |
|----------------------------------|------------|-----------|--------------------------------|------------|-----------|-------------------------------|---------------------|-----------|
| 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    |            |           | <b>Allergies:</b> <u>List</u> |                     |           |
| Hay Fever                        |            |           | Back Problems                  |            |           |                               |                     |           |
| Tuberculosis                     |            |           | Tumor, Cancer                  |            |           |                               |                     |           |
| Shortness of Breath              |            |           | Jaundice                       |            |           |                               |                     |           |
| Measles                          |            |           | Stomach or Intestinal Problems |            |           |                               |                     |           |
| German Measles                   |            |           |                                |            |           |                               | <b>Females only</b> |           |
| Mumps                            |            |           | Gallbladder Trouble            |            |           | Irregular Period              |                     |           |
| 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 above information 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.**

CONTINUED ON BACK

## Immunization Information

### Required Immunizations:

### Recommended Immunizations:

|   |   |
|---|---|
| MMR #1 _____ MMR#2 _____<br>Tetanus (within last 10 years) _____<br>Chicken Pox <input type="checkbox"/> disease <input type="checkbox"/> Varicella Vaccine | Hepatitis B 1. _____ 2. _____ 3. _____<br>Hepatitis A _____<br>Meningitis _____<br>HPV (females only) _____ |
|---|---|

### Physical Examination to be completed by a Physician

|  |   |   |
|--|---|---|
| <u>Urinalysis</u><br>Sugar _____ Albumin _____<br>Micro _____ Hemoglobin _____ | <u>BP</u> _____/_____<br>Height _____<br>Weight _____ | <u>Visual acuity</u><br>Right – 20/ ____<br>Left – 20/ ____ |
|--|---|---|

### 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<br>/ / |
| 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**