

PHYSICAL EXAMINATION FORM

To be filled out by Health Care Provider

Required of all Traditional students – Due two weeks prior to arrival/classes

PERSONAL DATA					
Last Name		First	Middle		Birthdate:
Height:	Weight:	Handed: Right Left	BP:	Pulse:	
Vision: Left Eye:		Right Eye:	Both Eyes:	Glasses or Contacts:	
Are there any abnormalities in the following systems?					
		Yes No		Yes No	
Head.....		<input type="checkbox"/> <input type="checkbox"/>	Musculoskeletal		
Eyes, Ears, Nose, or Throat		<input type="checkbox"/> <input type="checkbox"/>	• Neck	<input type="checkbox"/> <input type="checkbox"/>	
Respiratory.....		<input type="checkbox"/> <input type="checkbox"/>	• Shoulder	<input type="checkbox"/> <input type="checkbox"/>	
Cardiovascular.....		<input type="checkbox"/> <input type="checkbox"/>	• Elbow	<input type="checkbox"/> <input type="checkbox"/>	
Hernia		<input type="checkbox"/> <input type="checkbox"/>	• Wrist	<input type="checkbox"/> <input type="checkbox"/>	
Genitourinary		<input type="checkbox"/> <input type="checkbox"/>	• Hand	<input type="checkbox"/> <input type="checkbox"/>	
Metabolic/Endocrine		<input type="checkbox"/> <input type="checkbox"/>	• Back	<input type="checkbox"/> <input type="checkbox"/>	
Nervous System		<input type="checkbox"/> <input type="checkbox"/>	• Hip	<input type="checkbox"/> <input type="checkbox"/>	
Psychiatric (including eating disorders)		<input type="checkbox"/> <input type="checkbox"/>	• Thigh	<input type="checkbox"/> <input type="checkbox"/>	
Skin		<input type="checkbox"/> <input type="checkbox"/>	• Knee	<input type="checkbox"/> <input type="checkbox"/>	
Gastrointestinal.....		<input type="checkbox"/> <input type="checkbox"/>	• Ankle	<input type="checkbox"/> <input type="checkbox"/>	
			• Foot	<input type="checkbox"/> <input type="checkbox"/>	
			• Scoliosis	<input type="checkbox"/> <input type="checkbox"/>	
Does this student require a specific diet?					
Please list any medications (prescription & OTC including herbal & dietary supplements) and doses this student is taking:					
List hospitalizations & surgeries (providing details, including dates, diagnosis, and complications):					
List any injuries:					
CLEARANCE FOR SPORTS PARTICIPATION — (A copy of this form may be submitted to Admissions to be used as a sports physical.)					
_____ Cleared					
_____ Cleared after completing the evaluation/rehabilitation for: _____					
_____ Not cleared. Why: _____					
Signature of Examiner:					
Print Name:					
Address: Street		City	State	Zip	
Phone:					

Please submit to: admissions@highlandscollege.com OR mail to Highlands College / 3660 Grandview Parkway / Birmingham, AL 35243