PART B - PHYSICAL EXAMINATION

TO BE COMPLETED BY HEALTH CARE PROVIDER
(This record is a privileged communication and will be treated confidentially.)

____ ____/____/____

STUDENT'S LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH**

The state of North Carolina requires all students entering college to submit a valid copy of their immunization records to the college in order to register. (A valid copy may be obtained from your high school, family physician, health department, clinics, or other colleges you have attended). All shot records require verification by a doctor's stamp or signature or a clinic or health department stamp.

IMMUNIZATIONS	DATE	DATE	DATE
DTP/ DTP/ TD (ONE MUST BE WITHIN THE LAST 10 YEARS). Series of 3 required.			
Td Booster within the last 10 years.			
Polio, Series of 3 (not required after age 17)			
MMR (measles, mumps, rubella) Series of 2 required.			
Hepatitis B (Series of 3, if born after July 1, 1994)			
Meningitis Vaccine (Recommended, not required)			

Tuberculin Skin Test (within the last year)	**Date given:** **Signature:**	**Date Read: ______Results: ______mm** **Signature: ________________________**
Chest X-ray (if applicable)	**Date given:**	**Results:** (attach a copy of the chest x-ray report to form)

Health Care Staff Signature _____________________________________ Office Stamp__________________________

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

Height	**Weight ______lbs**	**B/P ________**	**Pulse**	**Hearing (gross) Right _____Left _____**

Corrected Vision: Right 20/ _______ Left 20/_______ | **Uncorrected Vision: Right 20/_________ Left 20/**

Urinalysis: Glucose Ketones Leukocytes Blood Protein HGB/HCT /

Are there any	Normal	Abnormal	Description (attach additional sheets if necessary)
1. Head, Ears, Nose, Throat			
2. Eye			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/ Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Mammary			

A. Is there loss or seriously impaired function of any organ? Yes No
Explain: ____
B. Is the student under treatment for any medical or emotional condition? Yes No
Explain: ____
C. Recommendations for physical activity (Phys. Ed., Intercollegiate, Intramurals, etc.)
Unlimited Limited Explain:____
D. Significant findings or general comments regarding this student. Is student physically and emotionally healthy?
Explain: ____________________

____

____

Signature of Physician/ Physician's Assistant/ /Nurse Practitioner **Physical Examination Date**

Office Address/ Stamp **City** **State** **Zip Code** **Area Code/ Phone Number**