

LASELL UNIVERSITY PHYSICAL EXAMINATION

Physical examination must be completed within 12 months prior to registration date by a health provider who is not a parent of this student.

Student's Name: _____ Date of exam: _____ Date of Birth: _____

Height _____ Weight _____ BMI _____ BP _____ Pulse _____ Vision test: OD _____ OS _____ OU _____

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lymph nodes		
Thyroid		
Lungs / Chest		
Breasts		
Cardiovascular		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurological		
Psychological		

If any blood tests are done, please include a copy of the results.

CURRENT AND CHRONIC PROBLEMS:

If the student is under care for a chronic condition or serious illness, please provide additional clinical reports to assist us in providing continuity of care.

SPECIAL DIETARY REQUIREMENTS: _____

CURRENT MEDICATIONS (include Vitamins, Over the Counter Medications, Contraceptives, Inhalers and Epi-Pens): _____

ALLERGIES to Medications: _____ Type of Reaction _____

Allergies to Other Things _____ Type of Reaction: _____

Has an Epi-pen been prescribed? _____

Recommendations for physical activity and/or sports participation: unlimited limited (specify)

Health Care Provider (please print) _____ Date _____

How long have you known this patient? _____

Address _____

Phone (_____) _____ Fax _____

Provider's Signature: _____

Return form to:

Lasell University Health Services
1844 Commonwealth Avenue
Newton, MA 02466

Phone: (617) 243-2451

Fax: (617) 243-2339

Email: healthservices@lasell.edu

VARSIY ATHLETES ONLY: The Athletic Trainer may have access to the physical examination report of students who elect to participate in athletics.

Physical Activity Clearance: Cleared Not Cleared Cleared with recommendation for further evaluation RE: _____

List any Restrictions: _____

STUDENT ATHLETES TAKING MEDICATION FOR ADD/ADHD WILL NOT BE ABLE TO OBTAIN PRESCRIPTIONS FROM THE LASELL UNIVERSITY HEALTH CENTER.
PLEASE MAKE ARRANGEMENTS FOR REFILL PRESCRIPTIONS WITH YOUR PATIENT AND COMPLETE THE ADHD
MEDICATION EXEMPTION FORM INCLUDED IN THIS PACKET.

Health Care Provider Signature _____ Date _____