LANCASTER BIBLE COLLEGE

# PHYSICAL EXAMINATION FORM

To be filled out by Health Care Provider

All full-time, undergraduate students must have a physical exam.

PERSONAL DATA

**Name:** Last 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 |
|---|---|---|
| 1. Head | ☐ | ☐ |
| 2. Eyes, Ears, Nose, or Throat | ☐ | ☐ |
| 3. Respiratory | ☐ | ☐ |
| 4. Cardiovascular | ☐ | ☐ |
| 5. Gastrointestinal | ☐ | ☐ |
| 6. Hernia | ☐ | ☐ |
| 7. Genitourinary | ☐ | ☐ |
| 8. Metabolic/Endocrine | ☐ | ☐ |
| 9. Nervous System | ☐ | ☐ |
| 10. Psychiatric (including eating disorders) | ☐ | ☐ |
| 11. Skin | ☐ | ☐ |
| 12. Musculoskeletal | | |
| Neck | ☐ | ☐ |
| Shoulder | ☐ | ☐ |
| Elbow | ☐ | ☐ |
| Wrist | ☐ | ☐ |
| Hand | ☐ | ☐ |
| Back | ☐ | ☐ |
| Hip | ☐ | ☐ |
| Thigh | ☐ | ☐ |
| Knee | ☐ | ☐ |
| Ankle | ☐ | ☐ |
| Foot | ☐ | ☐ |
| Scoliosis | ☐ | ☐ |

**Describe any abnormalities:**

**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:**

*continue on back*

# **PHYSICAL EXAMINATION FORM** continued

IMMUNIZATIONS AND TESTS

| **VACCINE** | **DOSES** (Enter month, day, and year each immunization was given) | | | **BOOSTERS & DATES** | |
|---|---|---|---|---|---|
| Diptheria and Tetanus (Circle): DTaP, DTP, DT, TD | 1 | 2 | 3 | 4 | 5 |
| Polio (Circle): OPV, IPV | 1 | 2 | 3 | 4 | 5 |
| Measles, Mumps, Rubella | 1 | 2 | | | |
| Hepatitis B | 1 | | 2 | | 3 |
| HIB | 1 | | 2 | | 3 |
| Varicella disease or vaccine | 1 | | 2 | | 3 |
| Meningitis | 1 | | 2 | | 3 |
| Other _____ | | | | | |

**All college students who live on campus in PA must submit proof that they have had the meningitis vaccine or sign a waiver if they chose not to have it.**

CLEARANCE FOR SPORTS PARTICIPATION — (A **copy** of this form may be submitted to Athletics to be used as a sports physical.)

_____ Cleared

_____ Cleared after completing the evaluation/rehabilitation for: _____

_____ Not cleared

Any student who wishes to participate in an NCAA sport LBC offers must have the physical exam filled out by a Health Care Provider dated *after* July 1 (of the year they are entering).

**Signature of Examiner:** Date

**Print Name:** Are you the regular provider?

**Address:** Street City State Zip

**Phone:**

**Please submit to:**

Admissions Office
901 Eden Road
Lancaster, PA 17601-5036

OR
Fax: 717.560.8213

**Email questions to:** nurse@lbc.edu