MOLLOY UNIVERSITY

Health Services 1000 Hempstead Ave., Wilbur Arts Center Rm 103B, Rockville Centre, NY 11571-5002
www.molloy.edu

T: 516-323-3467
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# PHYSICAL EVALUATION

All resident students **MUST** submit a physical evaluation completed by their Health Care Provider performed withing the last 12 months from the date of enrollment. This document must be signed and stamped by the Health Care Provider. We will also accept the provider's physical evaluation form if it is on the provider's letter head.

***NAME:*** _____ ***DOB:*** _____ ***MOLLOY ID#:***_____

***PHONE:*** _____ ***STUDENT EMAIL:*** _____ ***EXAM DATE:*** _____

| | |
|---|---|
| **BP_____/_____ HR_____ RR_____**<br><br>**HEIGHT_____FT____IN WEIGHT_____LBS___OZ**<br><br>**BMI_____**<br><br>**VISION:** Uncorrected or Corrected (please specify)_____<br><br>**HEARING:** Normal or Abnormal (please specify)_____ | **ALLERGIES (medications, food, latex, other):**<br>_____<br>_____<br>_____<br><br>**MEDICATIONS**:<br>_____<br>_____<br>_____ |

**Clinical Evaluation** – Describe each abnormality in the space provided. **Enter NA if not evaluated**

| | NORMAL (please check) | ABNORMAL FINDINGS |
|---|---|---|
| Head, Neck, Face, and Scalp | | |
| Nose and Sinuses | | |
| Mouth and Throat | | |
| Ears (perf of drum, etc.) | | |
| Eyes (lids, conjunctiva, etc.) | | |
| Pupils and Ocular Motion | | |
| Lungs | | |
| Heart | | |
| Vascular System (varicosities, etc.) | | |
| Abdomen and Viscera (include hernia) | | |
| Breast/ Pelvic Exam | | |
| Endocrine System | | |
| Genitourinary Male | | |
| Upper Extremities (strength, ROM) | | |
| Lower Extremities (strength, ROM) | | |
| Musculoskeletal Disorders | | |
| Skin and Lymphatics | | |
| Neurologic | | |
| Psychiatric (specify) | | |

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***NAME :*_____ *DOB:*_____*MOLLOY ID #*_____**

| | | |
|---|---|---|
| □ **No** | □ **Yes** | Is there loss or seriously impaired function of any paired organs? *If yes, please indicate***:** |
| □ **No** | □ **Yes** | Any recommendations for special dietary requirements or limitations of physical activity? *If yes, describe:* |
| □ **No** | □ **Yes** | To the best of your knowledge, is this person free from physical/mental impairments? *If No, indicate the physical/mental impairment:* |
| □ **No** | □ **Yes** | Immunization records provided to the student? |

**Tuberculosis Risk Assessment:**

Has the patient ever had a positive for TB blood/skin test result?

□ **NO** □ **YES** *If yes, please indicate below when and if the patient had a negative chest x-ray:*

_____

1. Has the patient ever taken anti-tuberculosis medication?
   □ **NO** □ **YES** *If yes, please specify below what medication(s), duration, and if treatment was completed:*

   _____

2. Does the patient have a medical condition, or are taking medications, which suppress your immune system?
   □ **NO** □ **YES** *If yes, please indicate condition/medications below:*

   _____

Upon completion of a complete physical examination, I have found this student capable of participating in a full program of college study, including participation in intercollegiate sports**.** □**YES** □**NO**

**COMMENTS:**

_____

_____

_____

**THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER (PHYSICIAN, NP, OR PA)**

**Provider Signature: _____** **PROVIDER STAMP**

**Provider Name: _____**

**Address: _____**

**Phone #: _____**