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

VARSITY 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** ____________________