Carthage College
2001 Alford Park Drive
Kenosha, WI 53140
262-551-8500

Physical Form

Name: Last First

Address City State Zip

Date of Birth (Month/Day/Year) Phone (home) (cell)

Sex: ☐ Male ☐ Female

Ht (in.)	Wt (lbs.)	Temp:	Pulse:	Resp:	BP:
Vision-Right Eye:			Vision-Left Eye:		
Allergies:			Current Meds:		

	NORMAL	ABNORMAL	COMMENTS
Head, Nose, Sinuses, Neck, Thyroid	☐	☐	
Mouth, Throat, Teeth & Gums	☐	☐	
Eyes	☐	☐	
Ears	☐	☐	
Skin	☐	☐	
Chest, Breasts, Lungs	☐	☐	
Heart, Vascular System	☐	☐	
Abdomen	☐	☐	
Muscular/Skeletal	☐	☐	
Neuro	☐	☐	

COMMENTS:

I have given a complete physical examination to_____, on this date_____and
(student name) *(date)*
in my opinion feel that she/he is in _____health and is capable of participating, without hazard, in clinical practice settings.

_____
Healthcare Provider's Name & Title (Please Print)

_____
Healthcare Provider's Signature