
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