



**MEDICAL EXAMINATION FORM (MEF)**

ID NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_  
LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ M.I.: \_\_\_\_\_  
GENDER:  FEMALE  MALE BIRTHDAY: \_\_\_\_\_ CONTACT NUMBER/S: \_\_\_\_\_  
COLLEGE / GRADE & SECTION: \_\_\_\_\_ ACADEMIC YEAR: \_\_\_\_\_  
PERSON TO NOTIFY IN CASE OF EMERGENCY: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
EMERGENCY CONTACT NUMBER/S: \_\_\_\_\_

**AUTHORITY TO CONDUCT MEDICAL EXAMINATION**

I, \_\_\_\_\_, \_\_\_\_ years old accept and understand that I am required to undergo an offsite entrance physical examination, blood typing, drug test and chest x-ray to determine my fitness and well-being as a student. I fully understand that the results will be held as confidential medical records and will be used by the University for my care and treatment. My health information cannot be released to third persons except with my consent or unless the disclosure of the information is required by the law. I also accept and understand that the procedures are requirements for official enrolment. I acknowledge that my medical records will be retained by the University for a period of 5 years from examination or health visit.

Signature of student \_\_\_\_\_

**Physical Examination consultation details**

**Consultation details and physical exam to be completed by the nurse/doctor**

Blood type \_\_\_\_\_  
Blood Pressure \_\_\_\_\_  
Resp. Rate \_\_\_\_\_  
Pulse rate \_\_\_\_\_  
Temperature \_\_\_\_\_  
Height (inches) \_\_\_\_\_  
Weight (pounds) \_\_\_\_\_  
BMI \_\_\_\_\_  
BMI category \_\_\_\_\_  
LMP (Female) \_\_\_\_\_

**Medical History (updated)**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Present medication(s):**

\_\_\_\_\_  
\_\_\_\_\_

**Social History**

Smoking  No  Yes: \_\_\_\_\_  
Drinking  No  Yes: \_\_\_\_\_  
Exercising  No  Yes: \_\_\_\_\_

**Laterality of extremities**

Right Handed  
 Left Handed  
 Ambidextrous (both hands)

Right Vision \_\_\_\_\_  
Left Vision \_\_\_\_\_  
 with corrective lens

Disability:  No  Yes  
With PWD card:  No  Yes  
Type of disability: \_\_\_\_\_

**Diagnosis/Impression:** \_\_\_\_\_

Physical Findings	Significant /Abnormal Findings
EENT <input type="checkbox"/> Normal	
Head and Neck <input type="checkbox"/> Normal	
Breast <input type="checkbox"/> Normal	
Lungs <input type="checkbox"/> Normal	
Heart <input type="checkbox"/> Normal	
Skin <input type="checkbox"/> Normal	
Abdomen <input type="checkbox"/> Normal	
Neurologic <input type="checkbox"/> Normal	
Chest X-ray <input type="checkbox"/> Normal	
Drug test <input type="checkbox"/> Normal	

**ASSESSMENT OF THE EXAMINING PHYSICIAN**

I certify that the above examination was conducted done with the following recommendation(s):  
 Physically Fit for academic activities  
 Physically Fit for academic activities with restrictions: \_\_\_\_\_  
 Pending classification.  For additional X-ray.  For clearance: (specialty / reason): \_\_\_\_\_  
Examining physician: \_\_\_\_\_ Assigned Nurse: \_\_\_\_\_  
License number: \_\_\_\_\_