WINSTON-SALEM STATE UNIVERSITY

Wellness Center – Student Health
601 S. Martin L. King Jr. Dr.
Suite 244, A. H. Ray Bldg.
Winston-Salem, NC 27110
Phone: (336) 750-3301
Fax: (336) 750-3303

A physical examination is required. This form must be completed in black ink and signed by a Physician, Nurse Practitioner or Physical Assistant.
Provider, please take a moment to counsel the future college student on lifestyle and social issues associated with the college experience.

Last Name	**First Name**	**Middle Name**	**DOB (mo/day/yr)**	**Banner #**	
Permanent Address	**City**	**State**	**Zip Code**	**Area Code**	**Phone #**

Height _____ **Weight** _____ **TPR**_____/_____/_____ **BP**_____/_____ **P. Ox:**_____

Vision: Corrected Right 20/_____ Left 20/_____
Uncorrected Right 20/_____ Left 20/_____
Color vision, if required_____

Hearing: (gross) Right_____ Left_____
(15ft.) Right_____ Left _____

Urinalysis: Sugar_____Albumin_____
Micro, if indicated_____

Hgb or Het: _____

Hbg A1C: _____

	NORMAL	ABNORMAL	NOT DONE	EXPLAIN ABNORMALITIES
General Appearance				
Head, Ears, Nose, Throat, Neck				
Eyes				
Respiratory				
Cardiovascular				
Mammary				
Gastrointestinal				
Hernia				
Genitourinary				
Musculoskeletal				
Metabolic / Endocrine				
Neuropsychiatric				
Skin				

A. Is there loss or seriously impaired function of any organs? No_____ If yes _____
Explain _____

B. Is student under treatment for any medical or emotional condition? No_____ If yes _____
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited_____ If limited _____
Specify limitations _____

D. Is student physically, mentally and emotionally healthy? Yes_____ If no _____
Explain _____

****ONLY FOR STUDENT ADMITTED TO A HEALTH SCIENCE PROGRAM****

Based on my assessment of the student's physical and emotional mental health on _____, he/she appears able to participate in activities of a health professional in a clinical setting. Yes _____ If no, please explain: _____

_____

_____ _____ _____
Signature of Physician, Nurse Practitioner, or Physician Assistant **Print Name of Examiner** **Date**

_____
Office Address, City, State Zip Code

_____ _____
(Area Code) Phone Number **Fax Number**

Revised: October 2021