

JOHNSON & WALES UNIVERSITY

The Alan Shawn Feinstein Graduate School

Physical Examination Form



Name			Entrance Date		
last	first	middle	/	mo.	yr.
Birth Date		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Soc. Sec. No.	
Home Address			City	State	Zip
Name of Parent or Spouse			Phone No. Home ()		
Medical Coverage			Phone No. Work ()		

(To be completed and signed by physician)

PERSONAL HISTORY

Height	Weight	Scalp	Mumps	Hepatitis	Peptic Ulcer	
Vision: Right	Left	Glasses	Contacts	Chicken Pox	Pneumonia	Urinary Infection
Nose	Throat	Teeth	Measles	Tuberculosis	Mononucleosis	
Ears			Hayfever	Asthma	Diabetes	
Mouth	Tonsils		Rheumatic Fever		Convulsions	
Lymph Glands		Thyroid	Other			
Chest - Lungs	Medication Allergies (specify)?					
Heart						
Blood Pressure		Pulse Rate				
Abdomen			Food Allergies	EpiPen?		
Hernia	Genitalia					
Spine	Other Allergies?					
Extremities						
Skin						
Neurological Examination	Regularly Taken Medications					
Emotional Stability						
Menses	Regularity					
Serology (Optional)						
TB Test or Chest X-Ray (required within last 6 months)	Operations, Injuries, or Disabilities, Limitations					
Date	Result					
Impressions:	Other Pertinent Information					

IMMUNIZATION HISTORY Show Dates

FAMILY HISTORY

Rubella			TD	General Health of Father	
Measles	#1	#2	Polio	General Health of Mother	
			Chicken Pox	General Health of Brothers and Sisters	
Hepatitis B Vaccine (<i>optional</i>)	#1	#2	#3	Family History of Tuberculosis	
Hepatitis A Vaccine (<i>optional</i>)	#1	#2		Has there been a history of any of the following conditions in your family?	
Meningitis Vaccine (recommended)				Heart Disease	Allergy
M.D.				Diabetes	Asthma
Signature	Date			Epilepsy	Cancer
Address				Other	

PERMISSION FOR TREATMENT

I hereby grant permission to Johnson & Wales University, or its authorized representatives, to furnish such medical care as my son/daughter/self may require, including examination, treatment and immunizations. This permission is conditioned upon the understanding that in the event of serious illness, or the need for hospitalization and/or major surgery, the University will use all reasonable efforts to contact me. Failure in such efforts, however, should not prevent the University from providing such emergency treatments as may be necessary.

Name of Student	
In Emergency Notify	Relationship
Daytime Phone ()	Evening Phone ()
Parent/Legal Guardian/Student Signature	Date

