LAREDO COLLEGE
HEALTH SCIENCE DEPARTMENT
PHYSICAL EXAMINATION FORM

Name_____ Date_____
Last First Middle Maiden

Address_____
Number/Street City State Zip Code

Home Telephone # _____

Application for Admission to: _____
Name of Program

Hospitalization Insurance information is available at the LC Business Office.

TO BE COMPLETED BY APPLICANT:

1. Describe any physical, psychological, or emotional illness or condition of more than one week's duration that you have had within the last 5 years.

2. List any medication you are taking for any illness or condition listed in question #1.

3. Describe serious injuries/operations you have had.

4. If you have ever had limitations placed upon the amount and type of physical exercise that you can perform, please describe.

5. Describe any effects of a previous illness or injury that presently limits your physical abilities.

6. List known allergies (medications, foods, insects, etc).

Created 5/11; RVSD 11/11; RVSD 10/14; RVSD 06/15; RVSD 2/16; RVSD 8/16; RVSD 9/16; RVSD 3/17; RVSD 5/17; RVSD 6/17; RVSD 8/17; RVSD 10/18

MUST BE COMPLTED BY A: U.S. Physician, Nurse Practitioner, or Physician Assistant

NAME _____ P-ID/SSN _____

Weight_____Height_____Temperature_____Pulse_____Respiration_____B/P_____

Head_____ Heart_____ Tumors_____

Skin_____ Abdomen_____ Orthopedic-Conditions_____

Varicose Veins_____ Lungs_____ Hernia_____

TESTS: Providers Discretion

Chest X-Rays: _____ Findings_____

Urinalysis: Findings._____

Blood Count: RBC_____ WBC_____ HGB_____ HCT_____

Serology: _____

Exam findings; recommendations, if any:

_____ _____ _____

Provider Name and Title (Print) **Signature of Provider** **Date**

Address _____

Number/Street **City** **State** **Zip Code**

The entire form must be completed. Please email completed form to the email associated with the program you are applying for. This information is strictly for use by the Health Science Department and will not be released to anyone without the applicant's consent.

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