MEREDITH COLLEGE

Raleigh, North Carolina

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STUDENT HEALTH CHECKLIST

- **Complete all portal forms by July 1.**
- **Upload the "Immunizations Form" and "Physical Examination Form" to the portal by July 1.**
- **Complete the insurance waiver or enrollment in the BCBS portal prior to the start of classes.**

PHYSICAL EXAMINATION FORM (Recommended for all students; Required for students under the age of 23, including transfer students)

To be completed and signed by healthcare provider. This form cannot be completed by a family member.

TO THE EXAMINING PHYSICIAN: Please review the student's medical history, immunization history, proof of PPD, and then complete the examination and general comments portion of this form.

Last Name _____ **First Name** _____ **MI** ___ **Date of Birth** _____

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

	YES	NO	Please explain
Has the student ever been a patient in any type of hospital? (Specify when, where and why.)			
Is the student currently receiving treatment for any medical and/or mental health condition?			
Has the student's academic career been interrupted because of a medical or mental health condition? (Please explain.)			
Is there loss or seriously impaired function of any paired organs? (Please describe.)			
Other than for a routine check-up, has the student seen a physician or health-care professional in the past six months? (Please describe.)			
Has the student had any serious illness or injuries other than those already noted? (Specify when, where and give details.)			

Physical Activity? ○ Unlimited ○ Limited

Explain: _____

Explain: _____

_____

Height	Weight	BP	Pulse	Temp.
Vision R 20/	L 20/	Corrected	Hearing (Gross) R	L

Are there abnormalities of the following systems?

System	Yes	No	System	Yes	No
1. Head, Ears, Nose, Throat			9. Musculoskeletal		
2. Eyes			10. Metabolic/Endocrine		
3. Respiratory			11. Neurological		
4. Lymphatic			12. Skin		
5. Cardiovascular			13. Psychiatric Describe fully.		
6. Gastrointestinal					
7. Hernia					
8. Genitourinary					

Only required if indicated by the TB Screening Form in the online student health portal

Tuberculin (PPD) Test (required within 12 months)	Date given: Date read:
Required Results	mm induration
Chest x-ray, if positive PPD	Date:
Results - Attach copy of the report	
Treatment, if applicable	Date:

X _____ Date ____ / ____ / ____

Signature of healthcare provider (Mandatory)

Print name of healthcare provider Date

Office address Area Code/Office Telephone