BRYN MAWR COLLEGE

Health Services
101 North Merion Ave Bryn Mawr, PA 19010
Phone: 610-526-7360
Website: https://www.brynmawr.edu/inside/offices-services/health-wellness-center

Student ID: _____
Student Cell Phone: _____
Send us a message: nurse@brynmawr.edu
Student Medical Portal: brynmawr.medicatconnect.com

Physical Examination Form

Last Name: _____First Name _____ Preferred Name_____ Date of Birth:_____

Instructions

The student named above has been admitted to Bryn Mawr College. While in attendance at Bryn Mawr, the student may receive health care services in Health Services. Is it beneficial for Health Services to have knowledge of the student's current and past medical history. In addition, the student's immunization history must be up to date. ***Providers are asked to complete, sign, and return this form to the student. Students are asked to upload the form to the Bryn Mawr College Student Medical Portal (brynmawr.medicatconnect.com) by July 1 for Undergraduate students & June 1 for Postbacs. Failure to submit a completed Health Record will result in the inability to register for the next semester classes.***

Health Conditions

Is this student currently under treatment for any medical or mental health condition? If yes, please include the condition and treatment plan:

Has this student suffered any major illness or injury in the past that we should be aware of?

Do you have any recommendations for this student's health care while at Bryn Mawr College?

Physical exam must be within 365 days prior to July 1st

Date of Physical Exam: _____ Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____.

General	WNL	Remarks:		Breasts	WNL	Remarks:	
HEENT	WNL	Remarks:		Abdomen	WNL	Remarks:	
Thyroid	WNL	Remarks:		GU	WNL	Remarks:	
Neck	WNL	Remarks:		Musculoskeletal	WNL	Remarks:	
Lungs	WNL	Remarks:		Pelvic *(If indicated)*	WNL	Remarks:	
Cardio	WNL	Remarks:		Neurological	WNL	Remarks:	

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Allergies

Please list all allergies to medications, foods, and other known reactions.
(If the student has no known allergies, please check the box below.)

- ☐ The student has no known allergies to medications.
- ☐ The student has no known allergies to foods.

Medication(s):		
Food(s):		
Do they have an EpiPen? ❑ Yes ❑ No		Reason:

Current Medication

(List of all prescription and nonprescription medications, including vitamins & herbal supplements, including dose and times per day.)

Name	Dose	Frequency	Related Diagnosis

Fit for Sport

(This section is MANDATORY, physical will not be considered complete until completed by clinician)

Is this student medically qualified to participate in intercollegiate, intramural or club sport activities? Yes _____ No _____
If no, please explain why: _____
_____
_____

Signature of Provider: _____ Printed Name : _____ Date Of Completed Exam: _____

Mailing Address: _____ Office Phone : _____