

ACCS Institution: _____

This portion is to be completed by a Physician.

Height _____ Weight _____ Skeletal Size: Small ___ Medium ___ Large ___ EL ___
B/P _____ Pulse _____ Respiration _____ Temperature _____

Laboratory Findings

Hemoglobin or Hematocrit _____ WBC _____ Serology _____
Urine: Sp.Gr _____ Alb _____ Sugar _____

Eyes			
Do you wear glasses?	<input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you wear contacts?	<input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Distant Vision	Without glasses	R20/	
	With glasses	R20/	
Near Vision	Without glasses	R20/	
	With glasses	R20/	

Ears			
Hearing normal?	<input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Are drums intact?	<input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Head, Neck and Face	Normal ()	Abnormal ()
Nose and Sinuses	Normal ()	Abnormal ()
Mouth and Throat	Normal ()	Abnormal ()
Teeth	Normal ()	Abnormal ()
Lungs and Chest	Normal ()	Abnormal ()
Heart	Normal ()	Abnormal ()
Vascular System	Normal ()	Abnormal ()
Abdomen	Normal ()	Abnormal ()
Endocrine System	Normal ()	Abnormal ()
Female: Breast	Normal ()	Abnormal ()
Female: Pelvic	Normal ()	Abnormal ()
Male: Genital	Normal ()	Abnormal ()
Male: Hernia	Normal ()	Abnormal ()

Present Health: ___ Good ___ Fair ___ Poor

Date of exam: ___ / ___ / ___

I certify that the above information is true.

Physician's Signature _____

Student's Signature _____

TO BE COMPLETED BY COLLEGE OFFICIAL

Date Received: _____

Signature: _____

Complete and return to: