No faxed copies will be accepted

This packet must be uploaded to the patient portal: https://dolphinhealth.lemoyne.edu

Or mailed via USPS:
Le Moyne College
Wellness Center for Health and Counseling
HEALTH SERVICES OFFICE
1419 Salt Springs Road Syracuse, NY 13214

Student Name: ____ ***Date of Birth:*** ____________________

PHYSICAL EXAMINATION

Height: _________ Weight: ___________ BMI: _____________ B/P: ________________ Pulse: _________________
Vision: Rt 20/__________ Lt 20/________ Corrected Rt 20/_________________________ Lt 20/_____________________
Hearing: Rt__________________ Lt__________________

General Development	Normal	Abnormal	Explanation
Head/Hair/Scalp			
Skin/Lymphatics			
Eyes			
ENT			
Mouth			
Neck/Thyroid			
Heart			
Lungs/Chest/Breast			
Abdomen (include hernia)			
GU			
Ano-rectal (pilonidal)			
Vascular System			
Neurological			
Musculoskeletal			

Urinalysis: S.G. ____________________ Protein ____________________ Glucose ____________________
Drug Allergies: ____
Current Medications/Supplements:____

Summary of abnormalities and/or recommendations, including emotional status.
(Please let us know if you have any concerns, both physical and emotional, about this student, that you would like to share with us.)

____
____
____

Is the student able to participate in all physical activity? _____Yes ____No ***If*** "No" what activities are to be limited or restricted?
____

Physician's Signature: ________________________________ **Date of PE:** ___________________________________
Physician's Name (Please Print): ____
Office Address: _________________________________ **Office Phone #: (_____)**___________________________