BOSTON COLLEGE

University Health Services
140 Commonwealth Ave Chestnut Hill, MA 02467
Phone: 617-552-3225| Website: bc.edu/UHS
Send us a message: uhs@bc.edu

Student Name: _____
BC Eagle ID: _____
Student Cell Phone: _____

Physical Examination Form

Students Last Name: _____ Students First Name: _____

Date of Birth: _____

Instructions

The above-named student has been admitted to Boston College. While in attendance at BC, the student may be eligible for and receive health care services at Boston College, University Health Services (UHS). It is beneficial for UHS to have knowledge of the student's current and past medical history. In addition, the student's immunization history must be up to date as defined by Massachusetts law.
Providers are asked to complete, sign and return this form to the student.
Students are asked to upload this form to the Health Services Portal by July 1 for Fall Enrollment and January 1 for Spring Enrollment.

Physical Examination

(Must be within 12 months prior to registration)

Date of Physical Exam: _____ **Height**: _____ **Weight**: _____ **BMI**: _____ **Blood Pressure:** _____ **Pulse:** _____

Please check each system below and indicate if it is normal or abnormal, please give details in the "explain abnormalities'' section. If needed please provide additional documentation.

System	Normal	Abnormal	System	Normal	Abnormal	System	Normal	Abnormal
Skin	☐	☐	Cardiovascular	☐	☐	Genitourinary	☐	☐
HEENT	☐	☐	Peripheral vascular	☐	☐	Endocrine	☐	☐
Lymph nodes	☐	☐	Lymphatic	☐	☐	Neurological	☐	☐
Thyroid	☐	☐	Abdomen	☐	☐	Psychological	☐	☐
Chest/Lungs	☐	☐	Pelvic (if indicated)	☐	☐	Heart murmur	☐	☐
Breasts	☐	☐	Musculoskeletal	☐	☐	Reflexes	☐	☐

Explain Abnormalities:

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 BC?

Fit for Sports

(This must be checked for participation in sports)

Is this student fit for Varsity or other sports? ☐Yes ☐ No

Any contraindications to contact or non-contact sports?

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Allergies

(Please list ALL allergies to medications, foods, and other known reactions)

Or

(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 food

Medication(s):

Food(s):

Other:

Do they have an EpiPen? ☐Yes ☐ No	Reason:

Current Medications

(List all prescription and non-prescription medications, including vitamins & herbal supplements, including dose and times per day)

Name	Dose	Frequency	Related Diagnosis

_____

Signature of Provider Printed Name Date

_____

Mailing Address Office Phone