

Southeastern Louisiana University
University Health Center
Physical Examination

Student's Name: _____

Date: _____

W#: _____

Skin				
Eyes	Left Eye: 20 /		Right Eye: 20 /	
Vision				
Ears				
Hearing				
Nose/Throat				
Neck				
Chest				
Heart				
Abdomen				
Hernia				
Extremities				
Neurological				
Blood Pressure Stats	/	Temp.	Resp.	Pulse
Comments				

I hereby certify that I have reviewed this patient's information. I have examined this patient and have found them to be free of communicable diseases. I have reviewed their records and find them current on all required immunizations.

Physician's Name: _____

Physician's Signature: _____