



# HARCUM

HARCUM COLLEGE

Department of Student Life  
Harcum Health Center  
750 Montgomery Avenue  
Bryn Mawr, Pennsylvania 19010  
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Email: tgordon@harcum.edu

NAME: \_\_\_\_\_  
LAST FIRST

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**TO THE EXAMINING HEALTHCARE PROVIDER: Please review the student's attached health data and complete this form. The information supplied will be used as a background for providing health care, if this is necessary; and for identifying any need for accommodation to facilitate the student's academic success. This information will be handled in accordance with all applicable law.**

Date of exam: \_\_\_\_\_ BP: R \_\_\_\_ L \_\_\_\_ PULSE: \_\_\_\_ HEIGHT: \_\_\_\_ WEIGHT: \_\_\_\_

	Normal	Abnormal	Remarks
General Health			
Skin			
Ears			
Neck (include thyroid exam)			
Lungs			
Heart			
Abdomen/hernia check			
Back			
Extremities			
Neurologic exam			

Vision: Uncorrected : OD \_\_\_\_\_ OS \_\_\_\_\_ Corrected: OD \_\_\_\_\_ OS \_\_\_\_\_

This Student is able to participate in all educational, physical and patient care activities: Yes\_\_\_No\_\_\_

If no, please indicate what restrictions, accommodations, or modifications, if any, will be required for this student.

\_\_\_\_\_

This student (does not/does) need antibiotic pre-medication for dental treatment.

Medical Summary: Note problems or suggestions for care:

\_\_\_\_\_  
\_\_\_\_\_

Health Care Provider (please print)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Signature: \_\_\_\_\_ MD/DO/CRNP Date of exam: \_\_\_\_\_