



**This document is no longer necessary**

Name: \_\_\_\_\_  
Last/Family First Middle

**STUDENT HEALTH SERVICES**

**THE UNIVERSITY OF WEST FLORIDA**



**FOREIGN STUDENT HEALTH INFORMATION PACKET**

Welcome to the University of West Florida. Your Student Health Center, located on campus, is here to provide for you general health and medical well being. All currently enrolled full-time and part-time student are eligible to use the clinic.

The University of West Florida requires that this form be completed PRIOR TO ADMISSION and returned to the University of West Florida, Student Health Services, 11000 University Parkway, Pensacola, Florida 32514-5750 USA. A return envelope is provided for your convenience. This information is confidential and will be used as a background for providing health care.

**If not completed in its entirety, this form will be returned. All supporting documents in a foreign language must be translated into English. Your application for admission will be considered only when ALL medical AND immunization requirements are completed**

**Return forms to:**  
**THE UNIVERSITY OF WEST FLORIDA**  
**STUDENT HEALTH SERVICES**  
**11000 UNIVERSITY PARKWAY**  
**PENSACOLA, FLORIDA 32514-5750**  
**USA**



PHYSICIAN'S EVALUATION

TO THE PHYSICIAN: A physical examination is required for each foreign student applicant and must be within one year prior to the applicant's planned term of enrollment. These medical data remain confidential and have no bearing on academic acceptability. This information is necessary to serve as a base for health care and for medical clearance for actual enrollment. All supporting documents must be translated into English.

Name: \_\_\_\_\_
Last/Family First Middle Maiden

Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs. Temp \_\_\_\_\_ F Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

PHYSICAL EXAMINATION:

- Skin .....Normal \_\_\_ Abnormal\_\_\_
Head, neck.....Normal \_\_\_ Abnormal\_\_\_
Face..... Normal\_\_\_ Abnormal\_\_\_
Nose and Sinuses.....Normal\_\_\_ Abnormal\_\_\_
Mouth and Throat.....Normal\_\_\_ Abnormal\_\_\_
Teeth.....Normal\_\_\_ Abnormal\_\_\_
Heart.....Normal\_\_\_ Abnormal\_\_\_
Lungs and Chest.....Normal\_\_\_ Abnormal\_\_\_
Vascular System.....Normal\_\_\_ Abnormal\_\_\_
Abdomen.....Normal\_\_\_ Abnormal\_\_\_
Endocrine System.....Normal\_\_\_ Abnormal\_\_\_
Spine.....Normal\_\_\_ Abnormal\_\_\_
Neurological.....Normal\_\_\_ Abnormal\_\_\_

- EYES:
Are glasses worn? No \_\_\_ Yes \_\_\_
Are contact lenses worn? No \_\_\_ Yes \_\_\_
Defective? No \_\_\_ Yes \_\_\_
Distant vision:
Right 20/\_\_\_ Corrected to 20/\_\_\_
Left 20/\_\_\_ Corrected to 20/\_\_\_

- EARS:
Is hearing normal? No \_\_\_ Yes \_\_\_
Are ear drums intact? No \_\_\_ Yes \_\_\_

Are muscle strength and function of the extremities normal and all digits present? No \_\_\_\_\_ Yes \_\_\_\_\_

MALE: FEMALE:
Hernia Normal\_\_\_ Abnormal\_\_\_ Breasts Normal\_\_\_ Abnormal\_\_\_
Genitalia Normal\_\_\_ Abnormal\_\_\_ Pelvic, if indicated Normal\_\_\_ Abnormal\_\_\_

PHYSICIAN'S OPINION. Is there or has there ever been any physical or emotional problem that may interfere with the student's adjustment to the University? NO YES (if yes, please explain) \_\_\_\_\_

Please itemize any regular prescription medication: \_\_\_\_\_

Comments \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Medical Degree \_\_\_\_\_

Physician's Name \_\_\_\_\_
Please type or print

Physician's Address \_\_\_\_\_

Stamp or ID number \_\_\_\_\_ Date of examination \_\_\_\_\_