Student Life Office
15 University Street, Greenville, South Carolina 29601 p: 864.282.3848 f: 864.282.3849 Email: registration@scgsah.org

PHYSICAL EXAMINATION 2023-2024

Due: May 31st

Student: **Mr. Miss (Circle One)**

Last	First	Middle	Preferred

This form must be completed in its entirety, signed and dated by a licensed physician or family nurse practitioner (FNP). The physical examination must be completed on this form and dated after 1/1/2023.

Physician's Examination

Height: in. %	**Weight: lb. BMI:**
Blood Pressure:	**Heart rate:**
Nutritional Status:	**Last Dental Exam: Last cleaning:**
General Appearance:	
Skin:	
Mental Status:	
Neurological:	
History of Seizures:	
HEENT:	
Vision: Left: Right:	**Requires Correction: □ YES □ NO**
History of Headache? □ YES □ NO	**If yes, treatment?**
Hearing:	
Pulmonary:	
Cardiovascular:	
GI:	
GU:	
Reproductive:	
History of Hernia? □ YES □ NO	**If yes, treatment?**
Musculoskeletal:	

Does the student currently receive physical therapy? □ YES □ NO
If yes, please describe the frequency and type:

Does the student have physical limitations? □ YES □ NO
If yes, please describe:

PHYSICAL EXAMINATION 2023-2024

Student: **Mr. Miss (Circle One)**

Last	First	Middle	Preferred

Medical History

Health Concern:	Current Treatment:
Chronic Medical Illness:	
Emotional/Mental Health: **(ie: OCD / Depression / ADHD / Anxiety)**	
Eating Disorders: **(ie: Anorexia / Bulimia / Purging)**	
Environmental:	
Childhood Illnesses:	

Previous Injury

Old/New	Type of Injury	Location of Injury	Treatment

Do you have any concerns related to this student participating in an intensive, rigorous program of academic and artistic study? □ YES □ NO

If yes, please share any concerns that would assist us in caring for this student.

Physician Completing Form

Physician's Name Printed		Physician's Signature	
Practice Name		**Date Exam Completed**	
Mailing Address	**City**	**State**	**Zip**
Telephone Number		**Fax Number**	