

**The College Of New Jersey International and Off-Campus Programs**  
**PHYSICAL EXAMINATION**

Name \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Last First month/day/year

Destination(s): \_\_\_\_\_ Reason: \_\_\_\_\_ Date of Departure: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Smoker?  Never  Current  Quit # \_\_\_\_ Years ago Cigarettes/Per Day/x # \_\_\_\_ Years

ETOH Use (describe): \_\_\_\_\_

Illicit Drug Use (describe): \_\_\_\_\_

Personal History of Mental Illness, including eating disorder? \_\_\_\_\_

If female, date of last PAP: \_\_\_\_\_ result: \_\_\_\_\_

Height: _____ Weight: _____ BP: ____/____ Pulse: _____	Vision: R) 20/____ L) 20/____ Corrected: <input type="checkbox"/> No <input type="checkbox"/> Yes ____glasses ____contact lenses <input type="checkbox"/> Did not bring corrective lenses
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	Normal	Abnormal	Remarks
EENT			
Mouth/Teeth			
Thyroid			
Lymph nodes			
Skin			
Lungs			
Heart			
Abdomen			
Extremities			
Genitalia/Hernia			
Reflexes			
Musculoskeletal (ROM, strength)			

**Comments/Recommendations:**

- CDC travel guidelines recommended for student to review.
- Needs diagnostic testing: \_\_\_\_\_
- Needs immunizations: \_\_\_\_\_
- Other: \_\_\_\_\_

- Fully Cleared to participate
- Cleared with the following limitations: \_\_\_\_\_
- Not cleared due to: \_\_\_\_\_
- Not cleared pending: \_\_\_\_\_

Examining Practitioner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Examining Practitioner's (Print name): \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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