

Name: _____ Date of birth: _____

PHYSICAL EXAMINATION

A PHYSICAL EXAMINATION WITHIN THE PAST 18 MONTHS IS REQUIRED.

TO THE HEALTH CARE PROVIDER: Please review the student's history and complete the physical exam form. The information supplied will be used as a background for providing health care.

Student's Name: _____ **Date of Exam:** _____

ABNORMALITIES:

No.	System	Yes	No	List number and describe abnormality
1.	Skin			
2.	Eyes			
3.	ENT			
4.	Neck, thyroid			
5.	Chest, lungs			
6.	Breasts			
7.	Heart			
8.	Abdomen			
9.	Genitalia			
10.	Pelvic (if indicated)			
11.	Back and spine			
12.	Extremities, joints			
13.	Neurological			
14.	Psychological			

Lab work recommended: Hgb/Hct: _____ Cholesterol: _____ Urine: Glucose: _____ Protein: _____ Micro: _____

Height: _____ **Weight:** _____ **BMI:** _____ **Pulse:** _____ **BP:** _____

CURRENT MAJOR AND CHRONIC PROBLEMS:

ACUTE OR MINOR PROBLEMS:

IF THE STUDENT IS UNDER CARE FOR A CHRONIC CONDITION OR SERIOUS ILLNESS, PLEASE PROVIDE ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

Hospitalizations: _____

Surgeries: _____

Reason and Date: _____

Type and Date: _____

I have known applicant for _____ years.

ALLERGIES (medications, foods, insect, venom): _____

Type of reaction: _____

CURRENT MEDICATIONS (include vitamins, OTCs, contraceptives): _____

POTENTIAL ATHLETES: Students are NOT eligible to practice or participate in intercollegiate, varsity or club sports until this form has been completed and submitted to Health Services.

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: Collision: *Hockey, Football, Rugby, Cheerleading*
 Contact: *Lacrosse, Baseball, Basketball, Soccer, Track*

Health Care Provider (please print): _____

Address: _____

Phone: () _____

FAX: () _____

Provider's Signature: _____

Date of Exam: _____