FRAMINGHAM STATE UNIVERSITY

HEALTH CENTER
Foster Hall, Framingham, MA 01701-9101
http://framingham.medicatconnect.com
P: (508) 626-4900

Name: _____ Date of birth: _____ FSU ID: _____

PHYSICAL EXAMINATION

A PHYSICAL EXAMINATION IS REQUIRED FOR ATHLETES ONLY.
THE EXAM MUST HAVE BEEN COMPLETED WITHIN THE PAST 18 MONTHS.

Date of Exam: _____

ABNORMALITIES:	**YES**	**NO**	**Describe Abnormality**
Skin			
HEENT			
Neck, Thyroid			
Chest, Lungs			
Breasts			
Heart			
Abdomen			
Genitalia			
Musculoskeletal			
Neurological			
Psychological			

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 the Health Center.

RECOMMENDATIONS FOR PHYSICAL ACTIVITY:
* CHECK ONE *

☐ **Collision:** *Hockey, Football, Rugby, Cheerleading, Men's Lacrosse*
☐ **Contact:** *Women's Lacrosse, Baseball, Basketball, Soccer, Softball, Baseball, Field Hockey, Volleyball*
☐ **Non-Contact:** *Cross Country*

Health Care Provider (please print): _____

Provider's Signature: _____ Date: _____

Office Address: _____ Phone: _____