PHYSICAL EXAMINATION (Must be within one year of July 1 for Fall admission, January 13 for Spring admission, within six months of enrollment for NCAA athletics. Cannot be completed by parent clinician.)

STUDENT'S NAME: DOB: (MM/DD/YY) DATE OF EXAMINATION: (MM/DD/YY)

HEIGHT: WEIGHT: BMI: BLOOD PRESSURE: PULSE:

LABORATORY REPORTS REQUIRED for INTERCOLLEGIATE ATHLETES ONLY
(Students will be required to have below lab testing during orientation if reports are not submitted. Fees will apply):

❑ SICKLE CELL SCREEN
Please provide copies of additional lab reports if applicable: evidence of immunity to an illness or disease, TB IGRA, cholesterol, endocrine or specialty labs, etc.

VISION:

	RIGHT	LEFT
UNCORRECTED	20/	20/
CORRECTED	20/	20/

CONTACT LENS ❑ YES ❑ NO

PRESCRIPTION:

	NORMAL	ABNORMAL DESCRIBE ABNORMALITIES
SKIN, LYMPH NODES	❑	❑
HEAD, NOSE, SINUSES	❑	❑
MOUTH, TEETH, GINGIVA	❑	❑
EARS (CANALS, DRUMS)	❑	❑
HEARING	❑	❑
EYES (SEE ABOVE)	❑	❑
THROAT, THYROID	❑	❑
LUNGS, CHEST	❑	❑
HEART	❑	❑
BREASTS	❑	❑
BACK	❑	❑
ABDOMEN	❑	❑
PELVIC (IF INDICATED)	❑	❑
EXTREMITIES, JOINTS	❑	❑
NEURO	❑	❑

LIST ALL CURRENT MEDICATIONS:

LIST ALL KNOWN ALLERGIES: (INCLUDE MEDICATIONS, FOOD, SUBSTANCE)

Please describe any significant illnesses, injuries, or hospitalizations in this patient's past history. Please comment on any physical or emotional problems that the health service should be aware of regarding this patient, including past history, medications, and current treatments. Provide copies of clinical records for continuity of care.

❑ **PLEASE CHECK IF THE STUDENT INTENDS TO PARTICIPATE IN INTERCOLLEGIATE ATHLETICS.** **PLEASE INDICATE TEAM**

Intercollegiate Athletes only - PE required within 6 months of enrollment. Attach required copy of sickle cell screening lab report.

RECOMMENDATION FOR PHYSICAL EDUCATION AND ACTIVITY:

UNLIMITED ❑ LIMITED ❑ EXPLAIN:

CLINICIAN'S NAME *(Not parent clinician)* CLINICIAN'S SIGNATURE (M.D., N.P., PA) TODAY'S DATE

ADDRESS TELEPHONE NO. FAX NO.