

Physical examination required for ALL incoming students, MUST be done within one (1) year prior to your first day of class.

Physical Examination required for ALL NCAA athletes, MUST be done no sooner than April 15.

NAME _____ D.O.B. _____
Last First Middle Month Day Year

Examination Date: _____
Month Day Year

Current prescription and nonprescription medication(s) with dosage(s): _____

Medication Allergies: () NO () YES: _____

Food Allergies: () NO () YES: _____

History of Anaphylaxis: () NO () YES, what was the trigger? _____ Does student carry an EpiPen or AuviQ? () NO () YES

MEDICAL and SURGICAL HISTORY, please indicate if student has a history of any of the following.

Anemia	YES	NO	COVID -19	YES	NO	Hypertension	YES	NO	Eating Disorder	YES	NO
Sickle Cell Disease	YES	NO	Inflammatory Bowel Disease	YES	NO	Marfan Syndrome	YES	NO	Skin Condition	YES	NO
Sickle Cell trait	YES	NO	Rheumatoid Arthritis (or JIA)	YES	NO	Headache Disorder	YES	NO	Celiac Disease	YES	NO
Infectious Mononucleosis	YES	NO	Lupus (SLE)	YES	NO	Head injury/Concussion	YES	NO	Immunocompromising condition	YES	NO
Positive PPD or QTB	YES	NO	Diabetes Mellitus	YES	NO	Syncope	YES	NO	ADHD	YES	NO
Active Tuberculosis	YES	NO	Thyroid Disorder	YES	NO	Kawasaki Disease	YES	NO	Anxiety	YES	NO
Asthma	YES	NO	Seizure Disorder	YES	NO	Arrhythmia-WPW, prolonged QT	YES	NO	Depression	YES	NO
									Bipolar Disorder	YES	NO

Provide details for any YES answers: _____

Prior Surgery? () NO () YES, provide details: _____

Prior Hospitalization? () NO () YES, provide details: _____

Please include recommendations that may be important for the care of this student: _____

Physical Examination: BP _____ P _____ HT _____ WT _____ BMI _____ Vision: R 20/ _____ L 20/ _____

	NORMAL	NOT EXAMINED	ABNORMAL - describe findings
General Appearance			
Head, Eyes, Ears, Nose, Throat			
Lymph Nodes			
Cardiovascular/Pulses			
Respiratory/Lungs			
Gastrointestinal			
Musculoskeletal			
Neurologic			# of Concussions _____
Skin			

REQUIRED FOR NCAA ATHLETIC PARTICIPATION:

Sickle cell trait testing is **REQUIRED**: () positive () negative

This student is medically cleared for sports participation: () Cleared () Not Cleared, provide details: _____

I certify that to the best of my knowledge the information provided on this form is true and complete.

Physician/Healthcare Provider's Signature _____ MD, DO, NP, PA-C DATE: _____

Office Address: _____

Office Phone: _____

Office Fax: _____

OFFICE STAMP