Physical Examination: *(Please type or print in black ink.)* ***RECOMMENDED***

Your physical examination must be completed by a health care professional

Last Name ______________________________ **First Name**______________________________ **Middle Name**_____________________

Date of Birth (MM-DD-YR)_________________________

Height___________ **Weight**___________ **TPR**_____/______/______ **BP**________/_________

Vision: **R** 20/_______ **L** 20/_______ **Corrected:** Y N **Color Vision:**_________________________

Hearing: **Gross** Right_____________ Left_____________ **15 Ft.** Right_____________ Left_____________

Lab Work:

Urinalysis Sugar:_____________ Albumin:_____________ Micro:_______________

Hgb or HCT (if indicated):___________________________________

Required for First-Year (Freshman and Transfer) Student Athletes Only:

Sickle Cell Trait Status (NCAA required; lab result must be attached): Positive Negative

	Normal	Abnormal	Describe
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Mammary			

Is there a loss or seriously impaired function of any paired organs? Yes _____ No _____

Please explain if yes____

Is the student under treatment for any medical or emotional condition? Yes _____ No _____

Please explain if yes____

Recommendation for physical activity Unlimited____ Limited____

Please explain if limited____

Is the student physically and emotionally healthy? Yes _____ No _____

Please explain if no____

____ ___________________

Signature of Physician, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant Date

____

Print name and title of health care professional, include office address and phone number with area code