WICKER WELLNESS CENTER

PHYSICAL EXAMINATION FORM – To Be Completed By Health Care Provider

UPLOAD FORM TO: Student Health Portal at www.union.studenthealthportal.com

Student Name: ____ **Date of Birth:**_____/______/________

Date of Physical Examination:_____/______/________ **Sport:**______________________________________

EXAMINATION		
Height Weight ☐ Male ☐ Female BMI		
BP / (/) Pulse Vision R 20/ L20/ Corrected ☐ Y ☐ N		
Urinalysis: Glucose Protein Hemoglobin Hematocrit		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
Eyes/ears/nose/throat		
Lymph Nodes		
Heart		
Pulses		
Abdomen		
Genitourinary		
Skin		
Neurologic		
Lungs		
Musculoskeletal		
Please list significant orthopedic history:		
Tuberculosis Risk Assessment Circle One:	LOW RISK	HIGH RISK: See TB Risk Form→ PPD and/or X-Ray

ALLERGIES
Allergies (Medications, food, environment, etc.):
Medications (Regularly taken or required - include birth control): ☐ YES ☐ NO
If **YES**, the following medication and dosage required:
Special dietary requirements:
Has patient ever been treated for psychological problems, substance abuse, or eating disorder? ☐ YES ☐ NO
Do you have any recommendations regarding the care of this student or other conditions needing follow-up at school? ☐ YES ☐ NO
If **YES**, explain:

SPORTS CLEARANCE
☐ **Cleared for all sports without restriction**
☐ **Cleared for all sports without restriction with recommendations for further evaluation or treatment for:**
☐ **NOT CLEARED**

HEALTH CARE PROVIDER SIGNATURE REQUIRED **Stamp Here:**

Name (please print)____
Address____
City_______________________________State_________Zip Code________________
Phone( )_________________________ Fax( )________________________

PROVIDER SIGNATURE______________________________**DATE**____/____/______