# WICKER WELLNESS CENTER

PHYSICAL EXAMINATION FORM – To Be Completed By Health Care Provider

**UPLOAD FORM TO:** Student Health Portal at https://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** | | |
| **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**____/____/_____