



WICKER WELLNESS CENTER

PHYSICAL EXAMINATION FORM—To be completed by a non-parental 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 LOW RISK HIGH RISK: See TB Risk Form→ PPD and/or X-Ray
 One: _____

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 ____/____/____