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 One:	LOW RISK	HIGH RISK

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**____/____/______