WICKER WELLNESS CENTER – PHYSICAL EXAMINATION FORM

(to be completed by a non-parental Health Care Provider)

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

Date of Physical Exam: _____ **NCAA Sport (if applicable):** _____

EXAMINATION

Height: **Weight:** **Male ( ) Female ( )** **BMI:**

BP: **Pulse:** **Vision R 20/** **L20/** **Corrected: Yes or No**

MEDICAL	NORMAL	ABNORMAL	MEDICAL	NORMAL	ABNORMAL
Appearance			Abdomen		
Eyes/ears/nose/throat			Genitourinary		
Neck			Skin		
Heart			Neurologic		
Lungs			Musculoskeletal		

Tuberculosis Risk Assessment *(circle one)*: **Low Risk or High Risk**

MEDICAL HISTORY

Significant medical, orthopedic, surgical history:

Please list all medications & dosage amounts:

Allergies (medications, food, environment, etc):

Has patient ever been treated for psychological problems, substance abuse or eating disorder? Yes or No

Do you have any recommendations regarding the care of this student or other conditions needing follow-up at school? Yes or No

If Yes, explain:

SPORTS CLEARANCE

( ) Cleared for all sports without restriction **( ) Cleared for all sports with restriction** **( ) Not Cleared**

HEALTH CARE PROVIDER SIGNATURE REQUIRED **Stamp Here (Required):**

Name (please print) _____

Address _____

City, State & Zip Code _____

Phone _____ **Fax** _____

PROVIDER SIGNATURE _____