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**
If Yes, explain:

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 (please explain)** **( ) Not Cleared**

HEALTH CARE PROVIDER SIGNATURE REQUIRED **Stamp Here (Required):**
Name (please print) _____
Address _____
City, State & Zip Code _____
Phone _____ **Fax** _____

PROVIDER SIGNATURE _____