

PHYSICAL EXAMINATION FORM
(To be completed, signed and dated by your Health Care Provider)

Student Name: _____ D.O.B. _____

Ht: _____ Wt: _____ BP: _____ P: _____ R: _____

Visual Acuity: OD20/ _____ OS 20/ _____ Last eye exam: ____/____/____ Contacts _____ Glasses _____

	Norm.	Abn.	N.E.	Comments:
Head				
Eyes				
Teeth				
Neck (incl. thyroids)				
Chest & Lungs				
Heart				
Abdomen				
Genitalia (incl. hernia)				
(Pelvic, if indicated)				
Rectal (if indicated)				
Spine				
Extremities & Joints				
Neurologic				
Skin				
Emotional status				
Urinalysis				

Are you aware of any other pertinent information pertaining to this student's health that has not been addressed in the history and physical?
Yes _____ No _____. If Yes, Please elaborate: _____

THE FOLLOWING IS REQUIRED OF ALL MOUNT ST. MARY'S STUDENTS

PPD (Tuberculin Skin Test) (Date must be within 1 year)	Date Given ____/____/____ Date Read ____/____/____ Results: _____ mm Chest x-ray (required if TB skin test is positive) Date of chest x-ray ____/____/____ Results: _____ Normal _____ Abnormal _____
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Date of last Td/Tdap Booster (must be within 10 years) ____/____/____

Date of Meningococcal Vaccine ____/____/____ Booster Date ____/____/____

YES NO This student is a member of an NCAA athletic team. If **YES**, complete this shaded section

This patient is cleared for full participation in NCAA college athletics _____
(Provider's Initials)

This patient is not cleared for full NCAA participation. The following restrictions are in place: _____

The NCAA requires that all NCAA athletes have documentation of their sickle cell trait status

- This patient has tested (-) for sickle cell trait. (Please attach documentation)
- This patient has tested (+) for sickle cell trait. (Please attach documentation)

This NCAA Student--Athlete agrees to release a copy of this physical to Mount St. Mary's Sports Medicine staff.
(Copies of immunization records are not required by the Sports medicine staff)

(Signature of NCAA Student-Athlete) (Date) (Sport)

(Provider's Office Stamp Here)

Providers' Signature

Date