

Physical Exam

Name _____ Date of Birth _____ Gender _____
Home address _____ City _____ State _____ Zip _____

This form is mandatory for all enrolling undergraduate students. Students planning to participate in University athletics must have this form completed and on file with the Student Health Center prior to the Pre-participation Physical Evaluation. The physical examination must be completed and signed by a physician or nurse practitioner to be valid.

Medical History: _____

Hospitalization/Surgery: _____

Allergies: _____

Medications: _____

temp: _____ pulse: _____ resp: _____ BP: _____

height: _____ weight: _____ BMI: _____

General appearance: _____

Skin: _____

HEENT: _____

Neck/Thyroid/Lymph Nodes: _____

Thorax/Lungs: _____

Cardiovascular: _____

Heart murmurs: (if indicated, please enclose EKG or ECHO reports) _____

Abdomen: _____

Breast/Gyn or Genitalia/Hernia: _____

Musculoskeletal: _____

Neurological: _____

Assessment: _____

Is this student capable of participating in University physical education courses or tryouts for intercollegiate sports?

Yes _____ No _____ Explain any exceptions : _____

Required Tuberculosis screening:

1. Does this student have signs and symptoms of active TB disease? Yes _____ No _____

2. Is this student a member of a high-risk group, or is the student entering a health profession? Yes _____ No _____

3. Is the student planning to participate in intercollegiate athletics? Yes _____ No _____

If "yes" to any of the above, and no history of previous Mantoux test within last 12 months, a Mantoux (PPD) or IGRA test is required.

Mantoux: date given: _____ date read: _____ results: _____ mm

(Must be read 48-72 hours of administration in mm. Positive results = ≥ 10 mm) or IGRA: attach copy of result

For a current or previous positive Mantoux or IGRA test, please submit radiologist report of chest x-ray and treatment history.

Required Tests for Intercollegiate Athletes:

Urinalysis: specific gravity _____ pH _____ glucose _____ ketones _____ protein _____ leukocytes _____

Hemoglobin: _____ Hematocrit: _____

Physician/NP address _____

Phone _____ Fax _____

Physician/Nurse Practitioner signature _____ Date _____