Wingate University

PHYSICAL EXAM AND HEALTH EVALUATION

TO THE EXAMINING PROVIDER: Please review the student's medical history and complete and sign the physical exam. Section A is required for ALL students. Section A and B is required for any student participating in intercollegiate sports/cheerleading. This information is strictly for the use of the Health Center and will not be released without student consent. Thank you for your cooperation in completing this form.

Student Name_____ Date of Birth_____
Last First Middle

Section A: ALL INFORMATION REQUIRED

Height_____ Weight_____ BP_____/_____ Pulse_____

Vision: Corrected Right 20/_____ Left 20/_____ Both 20/_____
Uncorrected Right 20/_____ Left 20/_____ Both 20/_____

GENERAL PHYSICAL	NML	ABNML	EXPLAIN
1. Head, Ears, Nose, or Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Eyes			
7. Genitourinary			
8. Musculoskeletal			
9. Metabolic/Endocrine			
10. Neuropsychiatric			
11. Skin			
12. Is there loss or seriously impaired function of any organ?			

REQUIRED PROCEDURES:	Date:
URINALYSIS	
Sugar	Level:
Protein	Level:
HEMOGLOBIN / HEMATOCRIT	

Section B: REQUIRED FOR STUDENT-ATHETLES

SPORT: _____

SPORTS PHYSICAL	NML	ABNML	EXPLAIN
Heart/Lungs:			
Max Imp.			
Sinus Rhythm			
Murmur			
Peripheral Pulses			
Breath Signs			
Eye Exam:			
Pupils			
Fundi			
Ocular Muscles			
Vision			
Abdominal Exam:			
Wall Herniation			
Testicular Exam			
Liver/Spleen			
Orthopedic Exam:			
Muscle-Strength			
Neck			
Shoulders			
Elbows			
Hands			
Knees			
Ankles			
Feet			
Back/Spine			
Hand Dominance	Right	Left	

Recommendations for Physical Activity? ◯ Limited ◯ Unlimited ◯ N/A Explain: _____

_____

Is the patient under treatment for any medical or emotional condition? Yes____ No_____ Explain: _____

_____

Does student take any medication regularly? Yes____ No____ If yes, list medication and dosage: _____

_____

General Comments? Yes_____ No_____ Explain: _____

Does this student have a condition requiring special housing considerations? Yes____ No____ If yes, please explain thoroughly (attach if needed):

_____

Signature of Medical Provider: _____ Date Physical Completed: _____

Please print medical provider's name: _____ Business Phone: _____

Address or Office stamp: _____

IMMUNIZATION REQUIREMENTS

_____ / _____ / _____

Last Name First Name Middle Name Date of Birth (mo/day/year)

TO THE EXAMINING PROVIDER: Please review the immunization history and update ALL necessary immunizations. All dates MUST include month, day, and year.

The North Carolina Immunization Law requires that students entering college present to the school authorities immunization certification. Please note that if this requirement is not met, dismissal from school 30 days after registration is mandatory under the law. Please do your part to make sure you have the minimum immunizations required before sending in your forms.

IMMUNIZATION RECORD	To be completed and signed by examining medical provider. A complete immunization record from a medical provider or clinic may be attached to this form.			
SECTION A: REQUIRED IMMUNIZATIONS	Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year
DTaP/DTP/Td (3 doses)	#1	#2	#3	#4
Tdap/TD Booster (All students MUST show proof of a Tdap booster)	#1			
Polio (3 doses)	#1	#2	#3	
MMR (after 1st birthday)(2 doses)	#1	#2		
OR				
*Measles (after 1st birthday)(2 doses)	#1	#2	Disease Date	Titer Date & Result
*Mumps (2 doses)	#1	#2	(Disease Date NOT Accepted)	Titer Date & Result
*Rubella (1 dose)	#1	#2	(Disease Date NOT Accepted)	Titer Date & Result
Hepatitis B (3 doses)	#1	#2	#3	Titer Date & Result
Meningococcal (Menactra, Menveo, Menomune, APSV4, MCV4)	#1	#2		
Tuberculin (PPD) Test (one test required within last 12mos.)	Date Given	Results	Date Given	Results
	Date Read	mm Induration	Date Read	mm Induration
Chest x-ray, if positive PPD Treatment, if applicable (***Please attach Chest X-ray results)	Date of Chest X-ray	Results		
	Date			
Varicella (chicken pox) (2 doses) (required for Pharmacy, PA, Nursing, DPT and Athletic Training only)	#1	#2	Titer Date & Result	

SECTION B: RECOMMENDED IMMUNIZATIONS	Month/Day/Year	Month/Day/Year	Month/Day/Year
Influenza (annually)	#1	#2	#3
Human Papillomavirus (HPV) (Cervarix, Gardasil, Gardasil-9)	#1	#2	#3
Hepatitis A	#1	#2	
Hepatitis A/B combination series	#1	#2	#3
Meningococcal B Vaccine (Bexsero/Trumenba)	#1	#2	

_____

Name of Medical Provider (Print) Date Signature of Medical Provider

_____

Office Address (Area Code) Office Number