PHYSICIAN COMPLETES THIS FORM

PHYSICAL EXAMINATION

Please return directly to Fisher College Health Services.

Must be completed within one year of August 1 for fall enrollment, January 1 for spring enrollment, and within six months of enrollment for athletics.

Student's Name: _____ Date of Birth: _____

Height _____ Weight _____ BP _____ Pulse _____

Hearing: Right _____ Left _____

Vision: Without correction: Right 20/ _____ Left 20/ _____ With correction: Right 20/ _____ Left 20/ _____

Color vision normal: ☐ Yes ☐ No

The Athletic Trainer may have access to the physical examination report of students who elect to participate in athletics.

System	✓ if NORMAL	Describe Abnormality
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if indicated)		
Genito-urinary/Reproductive		
Pelvic		
Lymphatic		
Musculo-skeletal		
Neurological		
Endocrine		
Psychological		
Teeth/Mouth		
Lab work: Hgb/Hct_____ Urine: Glucose_____ Protein_____		

List all current medications:

List all known allergies
(medications, food, substances)

CURRENT MAJOR AND CHRONIC PROBLEMS:

ACUTE OR MINOR PROBLEMS:

If the student is under care for a chronic condition or serious illness, please provide additional clinical reports to assist us in providing continuity of care.

Please comment on any physical or emotional problems that Health Services should be aware of regarding this patient, including past history, medications, and current treatments:

☐ Please check if the student intends to participate in intercollegiate athletics. Please indicate team: _____

INTERCOLLEGIATE ATHLETES ONLY: PE required within 6 months of enrollment. Attach a copy of sickle cell screening lab report, required. Attach physicians certification of any NAIA banned substance with diagnosis, Rx, date prescription began, date of last evaluation, history of treatment (previous or ongoing), ADHD rating scale (if applicable), note that alternative non-banned substances have been considered.

Recommendations for physical activity: ☐ unlimited ☐ limited (specify) _____

☐ Medically cleared for sports participation ☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Do not clear. Reason: _____

MUST BE VERIFIED BY A LICENSED HEALTH CARE PROVIDER (please print) **DATE OF EXAM:** _____

Health Care Provider _____ MD, NP, PA, DO

Address _____

Phone (_____) _____ Fax (_____) _____

Provider's Signature: _____

Please return to Health Services @ 118 Beacon Street, Boston, MA 02116

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