

Physical Exam to be Completed by Healthcare Provider

Please print this form, have it completed by your provider, then upload it to the Patient Portal.

Name (Last, First, Middle initial):

DOB:

General Medical Exam		
	Normal	Abnormal
Appearance		
Skin		
Head and neck		
Eyes		
Ears		
Nose		
Throat		
Lymph nodes		
Heart		
Lungs		
Abdomen		
Neuro		
Musculoskeletal Exam		
Neck		
Back		
Shoulder		
Arm		
Leg		
Hip and thigh		
Knee		
Ankle		
Foot		

Physical Education/Intercollegiate/Club Sports Participation:

Sport(s) participating in:

- Cleared
 Cleared with coach notification
 Deferred clearance
 Not cleared
Explain:

Sickle Cell Blood Test:
 Negative
 Trait
 Disease

Healthcare Provider

Name (print):

Date:

Address:

Signature:

Telephone:

Immunization Record

Name (Last, First, Middle initial):

DOB:

Vaccine	1st Dose	2nd Dose	3rd Dose	4th Dose
MMR (required)				
COVID-19				
Diphtheria, Tetanus, Acellular Pertussis (DTaP)				
Hepatitis A				
Hepatitis B				
HPV (Human Papillomavirus)				
Meningococcal (MenACWY, Menactra, Menveo, Men-Quadfi)				
Meningococcal Serogroup B (Men B - Bexsero, Trumenba)				
Pneumococcal Conjugate (PCV13)				
Pneumococcal Polysaccharide (PPSV23)				
Polio (Inactivated) (IPV)				
TD, Tdap				
Varicella				

Healthcare Provider

Name (print):

Date:

Address:

Signature:

Telephone: