

Name (last, first, middle initial): _____ DOB: _____

Physical Examination:

Gender _____ Age _____ Height _____ Weight _____ BMI _____ (optional)

Blood Pressure _____ / _____ Pulse _____ LMP: _____

Vision R 20 / _____ L 20 / _____ Corrected ___ No ___ Yes Glasses/Contacts Red/Green _____

Sickle Cell Blood Test: Neg ___ Trait ___ Disease ___
(athletes only)

Comments _____

(4) Medical	Normal	Abnormal Findings
Appearance		
Skin		
Head, eyes, ears, nose, throat, teeth		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Neuro		

(5) Musculoskeletal	Normal	Abnormal Findings
Neck		
Back		
Shoulder, arm		
Elbow, forearm		
Wrist, hand		
Hip, thigh		
Knee		
Leg, ankle		
Foot		

Any evidence of emotional instability? _____

General health recommendations _____

Physical Education / Intercollegiate/Club Sports Participation:

Sport(s) participating in _____

- cleared cleared/with coach notification deferred clearance not cleared

Explain _____

Healthcare Provider:

Name (print): _____ Date: _____

Signature: _____

Address: _____ 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: