ELMS COLLEGE

MEDICAL EXAMINATION
To be completed in full

291 SPRINGFIELD STREET • CHICOPEE, MA 01013-2839 • 413-594-2761 • WWW.ELMS.EDU
HEALTH CENTER (PHONE) 413-265-2288 • (FAX) 413-592-9939

To the examining clinician: Please review the student's history and complete the physicians form. Please comment on all positive answers. ***This student has been accepted.*** The information supplied will not affect his/her status: it will be used as background for providing health care, if necessary. Information is strictly for use by Health Services and will not be released without student consent.

Last Name (surname) First Name Middle Name

Student I.D. Number

Date of Birth (mo/day/yr)_____Height _____ Weight_____Blood pressure_____ Pulse _____

Are there any abnormalities of the following:

				6.	neurologic/seizures	Y	N
1.	skin, blood	Y	N	7.	genitourinary	Y	N
2.	eyes, head, ear, nose, throat	Y	N	8.	musculoskeletal	Y	N
3.	respiratory	Y	N	9.	metabolic/endocrine	Y	N
4.	cardiovascular	Y	N	10.	hernia (males only)	Y	N
5.	gastrointestinal	Y	N		testes_____hernia_____tanner_____		

If "yes" to any of the above explain_____
Allergies _____

Define activities to be restricted, if applicable: _____

Provider signature_____ Date of exam _____

Provider address _____ Telephone _____

Recommendations for physical activity: ❑ Unlimited ❑ Limited

Is the student fit to participate in collegiate competition? ❑ Yes ❑ No

Required for all participants on athletic teams:
Sickle Cell lab report (please attach)
Urinalysis_____HGB or HCT_____

Femoral pulse (indicate 1-4+) R_____L_____
Apical heart rate Lying_____
Sitting_____