ELMS COLLEGE

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MEDICAL EXAMINATION

To be completed in full

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 student 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:

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

If "yes" to any of the above explain_____

Allergies _____

Define activities to be restricted, if applicable: _____

Recommendations for physical activity: ☐ Unlimited ☐ Limited

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

Provider signature_____ Date of exam _____

Provider address _____ Telephone _____

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_____