

WARTBURG COLLEGE PHYSICAL EXAMINATION FORM

(To be completed by Physician/Health Care Provider and submitted to Noah Campus Health Clinic by August 1)

Athletic Participant: Y N **Sport(s):** _____

Year in College: 1st 2nd 3rd 4th **Transfer** **International**

Name: _____
(First) (Middle) (Last)

Birth Date: _____ **Sex:** M F Other: _____
(Month) (Day) (Year) **Gender:** _____

Blood Pressure: _____/_____ **Pulse:** _____

Height: _____ (inches) **Weight:** _____ (pounds)

Vision: R: 20/___ L20/___ **Corrected:** Y N **Pupils:** Equal__ Unequal__

Allergies: _____

REQUIRED IMMUNIZATIONS

(Below are requirements of Wartburg College)

MMR #1: (mm/dd/yr) _____

MMR #2: (mm/dd/yr) _____

Tdap (mm/dd/yr) _____

HIGHLY RECOMMENDED IMMUNIZATIONS

Meningococcal/Meningitis

MCV4 #1: (mm/dd/yr) _____

MCV4 #2: (mm/dd/yr) _____

Men B #1 (mm/dd/yr) _____

Men B #2 (mm/dd/yr) _____

Medical	Normal	Abnormal Findings
Appearance		
Eyes, Ears, Nose, Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neck		
Musculoskeletal		
Neck		
Back		
Shoulders/Arms		
Elbows/Forearms		
Wrists/Hands/Fingers		
Knees		
Legs/Ankles		
Foot/Toes		

Clearance for Athletics

_____ Cleared for participation in (list sports) _____

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not cleared for _____ Reason: _____

Health Care Provider (signature required)

Date: _____ Signature: _____

Clinic Name: _____ Provider Name: (Print): _____

Address: _____

Phone: _____ Fax: _____

Physical Exam Form – to be completed by the student

Name _____ Sex _____ Age _____ Date of Birth _____
 Year in College: _____
 Address: _____
 Personal Physician: _____ Drug Allergies _____
 Current Medications _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (w) _____
 (cell) _____ Address: _____

Explain "Yes" answers below.

Circle questions you don't know the answer to.

	Yes	No		Yes	No																
1. Do you have any ongoing medical condition (like diabetes, asthma, high blood pressure, heart murmur, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	26. Does anyone in your family have Marfan Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>																
2. Are you currently under any treatment for any emotional condition?	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>																
3. Are you currently taking any prescription or non-prescription (over the counter) medicine or pills, including an inhaler or asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>	28. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>																
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	29. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
5. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	30. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>																
6. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
7. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>	32. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
8. Were you born without or are you missing a kidney, an eye, a testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	33. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>																
9. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	34. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle the affected area below:	<input type="checkbox"/>	<input type="checkbox"/>																
10. Have you ever had a head injury, concussion, been confused, or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>																
11. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:																		
12. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>																			
13. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper arm</td> </tr> <tr> <td>Elbow</td> <td>Forearm</td> <td>Hand/fingers</td> <td>Chest</td> </tr> <tr> <td>Upper back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> </tr> <tr> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/Toes</td> <td></td> </tr> </table>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/fingers	Chest	Upper back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/Toes			
Head	Neck	Shoulder	Upper arm																		
Elbow	Forearm	Hand/fingers	Chest																		
Upper back	Hip	Thigh	Knee																		
Calf/shin	Ankle	Foot/Toes																			
14. Has the doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>																			
15. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	37. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>																
16. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	38. Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>																
17. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you ever had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>																
18. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>																
19. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>																			
20. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY																		
21. Do you have any concerns you would like to discuss with the doctor?	<input type="checkbox"/>	<input type="checkbox"/>	41. How old were you when you had your first menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>																
22. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram).	<input type="checkbox"/>	<input type="checkbox"/>	42. Are your periods regular?	<input type="checkbox"/>	<input type="checkbox"/>																
23. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	43. How many periods have you had in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>																
24. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here: _____																		
25. Has any family member or relative died of heart problems or sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>	_____																		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student _____ Date: _____
 Signature of parent/guardian _____ Date: _____