WARTBURG COLLEGE PHYSICAL EXAMINATION FORM

(To be completed by Physician/Health Care Provider and submitted to the **Student Life Office** 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) _____
COVID-19: Brand _____
(mm/dd/yr)_____(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
1. Do you have any ongoing medical condition (like diabetes, asthma, high blood pressure, heart murmur, etc)?		
2, Are you currently under any treatment for any emotional condition?		
3. Are you currently taking any prescription or non-prescription (over the counter) medicine or pills, including an inhaler or asthma medicine?		
4. Do you have allergies to medicines, pollens, foods, or stinging insects?		
5. Have you ever had surgery?		
6. Do you regularly use a brace or assistive device?		
7. Is there anyone in your family who has asthma?		
8. Were you born without or are you missing a kidney, an eye, a testicle or any other organ?		
9. Have you had infectious mononucleosis (mono) within the last month?		
10. Have you ever had a head injury, concussion, been confused, or lost your memory?		
11. Have you ever had a seizure?		
12. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?		
13. Have you ever been unable to move your arms or legs after being hit or falling?		
14. Has the doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?		
15. Have you had any problems with your eyes or vision?		
16. Do you wear glasses or contact lenses?		
17. Are you happy with your weight?		
18. Are you trying to gain or lose weight?		
19. Has anyone recommended you change your weight or eating habits?		
20. Do you limit or carefully control what you eat?		
21. Do you have any concerns you would like to discuss with the doctor?		
22. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram).		
23. Has anyone in your family died for no apparent reason?		
24. Does anyone in your family have a heart problem?		
25. Has any family member or relative died of heart problems or sudden death before the age of 50?		

	Yes	No
26. Does anyone in your family have Marfan Syndrome?		
27. Have you ever spent the night in a hospital?		
28. Has a doctor ever denied or restricted your participation in sports for any reason?		
29. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
30. When exercising in the heat, do you have severe muscle cramps or become ill?		
31. Have you ever had discomfort, pain, or pressure in your chest during exercise?		
32. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
33. Does your heart race or skip beats during exercise?		
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:		
35. Have you ever had any broken or fractured bones or dislocated joints? If yes, circle below:		
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:		

Head	Neck	Shoulder	Upper arm
Elbow	Forearm	Hand/fingers	Chest
Upper back	Hip	Thigh	Knee
Calf/shin	Ankle	Foot/Toes	

37. Have you ever had a stress fracture?		
38. Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability?		
39. Have you ever had a herpes skin infection?		
40. Do you wear protective eyewear, such as goggles or a face shield?		

FEMALES ONLY

41. How old were you when you had your first menstrual period? _____
42. Are your periods regular? | | |
43. How many periods have you had in the last 12 months? _____

Explain "Yes" answers here:_____

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: _____