# 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) _____
MenB #1 (mm/dd/yr) _____
COVID-19: Brand _____
(mm/dd/yr)_____ (mm/dd/yr)_____
Booster: (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 your 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 your 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 your 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 in your chest 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 period 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: _____