PHYSICAL EXAMINATION

(Must be completed within the past twelve months)

Student Name ______________________________ **Date of Exam** ____________________

Height ________ Weight ________ BP __________ Pulse ________ Hearing: Right ________ Left ________

Vision: Without correction: Right 20/_____ Left 20/____ With correction: Right 20/______ Left 20/_______

The Athletic Trainer may have access to the physical examination report of students who elect to participate in athletics.

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Respiratory		
Breast		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		

Lab Work (if indicated): Hgb/Hct:______ Cholesterol: _______ Urine: Glucose: _______ Protein:_______ Micro: _______

CURRENT MAJOR & CHRONIC PROBLEMS

____
____
____

ACUTE & MINOR PROBLEMS

____
____
____

If the student is under care for a chronic condition or serious illness please provide additional clinical reports to assist us in providing continuity of care.

Additional comments and recommendations:______________________________

____

Please list any special **DIETARY REQUIREMENTS:** ______________________________

Please list all **ALLERGIES** (including medications, insect venom, foods, etc): ______________________________

Type of reaction ______________________________

Please list all **MEDICATIONS** currently being taken (include OTC's contraceptives): ______________________________

____

Recommendations for physical activity: ☐ unlimited ☐ limited (specify) ______________________________

Health Care Provider (please print) ______________________________

Address ______________________________

Phone (___) ____________________ Fax (___) ____________________

Provider's Signature ______________________________

Mail completed form to:
UMASS Lowell
Student Health Services
71 Wilder Street, Suite 5
Lowell, MA 01854-3091
Telephone: (978) 934-4991

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