

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		
Breasts		
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
Fax: (978)934-3080