ROBERTS WESLEYAN UNIVERSITY

PHYSICAL EXAMINATION

**REQUIRED for student athletes*
**Not required for traditional students, but recommended*

Section 2: To be completed by physician or qualified health provider

Student Information				
Name:			**Date of Birth:**	
Intercollegiate Sport(s)			**Gender:**	
Date of Physical			**Year in School: FR SO JR SR**	
Examination **Athletic physical must be dated within 6 months of sports participation *Nursing physical within 1 year of clinical work*				
Height:	**Weight:**	**BP:**	**Pulse:**	**BMI:**
Vision Corrected: ☐ **Yes** ☐ **No**		**L 20/**	**R 20/**	**Pupils: Equal / Unequal**

	Normal	**Abnormal or significant findings**
General		
Appearance		
HEENT		
Lung		
Hearth Murmurs (auscultation standing, supine)		
Endocrine/Lymph Nodes		
Abdominal		
Genialia (males only)		
Pulses Radial pulses & simultaneous femoral		
Neurologic		
Skin		
Musculoskeletal		
Neck/Shoulder/Back		
Arm/Elbow/Wrist/Hand/Fingers		
Leg/Hip/Thigh/Knee		
Ankle/Foot/Toes		

Does the student have drug allergies? If yes, please list by name and type of reaction: _____

_____

_____

Recommendations/Comments regarding the chronic condition or serious illness continuing care of the student:

_____

_____

Comments/Concerns regarding student's emotional wellness: _____

_____

❒ Cleared to participate in a full program college study
❒ Cleared for all sports without restrictions
❒ Cleared for all sports without restriction, with recommendations for further evaluation or treatment for _____
❒ Not cleared for sports
❒ Not cleared for college study
❒ Pending further evaluation

Reason and recommendations: _____

_____

Medical provider signature/stamp or a copy of the medical provider's document must be attached.

Physician's Stamp

_____ _____
MD, NP, or PA's Signature Date

_____
MD, NP, or PA's Printed Name

_____
Address, City, State