

**NOTE: ALL FORMS MUST BE SUBMITTED AS SOON AS POSSIBLE AND NO LATER THAN AUGUST 1<sup>ST</sup> FOR FALL ENTRY, JANUARY 1<sup>ST</sup> FOR SPRING ENTRY, AND MAY 1<sup>ST</sup> FOR SUMMER ENTRY**

**Springfield College Health Center  
PHYSICAL EXAMINATION**

Student's Name: \_\_\_\_\_ Identification # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Sex (circle one): Male Female

**NOTE:** For Student Athletes, Physical Exam must be performed within 6 months prior to first practice  
For Non-Athletes, Physical Exam must be performed within 1 year prior to first day of classes

**EXAM DATE:** \_\_\_\_\_ Physical Exam must be completed by a health care provider (MD, DO, NP, PA)

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Blood Pressure:** \_\_\_\_\_ **Pulse:** \_\_\_\_\_

**LABORATORY TESTS:** (Preferred but not required)

Hgb or HCT \_\_\_\_\_

Urinalysis: glucose: \_\_\_\_\_ protein: \_\_\_\_\_ blood: \_\_\_\_\_

Other: \_\_\_\_\_

<b>VISION</b>	<b><u>RIGHT</u></b>	<b><u>LEFT</u></b>
Uncorrected	20 /	20 /
Corrected	20 /	20 /
Contact Lens? (Circle one)	YES NO	
Glasses? (Circle one)	YES NO	

<b>PHYSICAL EXAMINATION</b>	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>DESCRIBE ABNORMALITIES</b>
Skin and Lymph Nodes			
Head, Neck, Thyroid			
Eyes			
Ears and Hearing			
Nose, Sinuses, Throat			
Mouth, Teeth, Gingiva			
Lungs and Chest			
Heart and Cardiovascular			
Abdomen			
Genitalia, Hernia			
Neurological Exam			
Musculoskeletal: ROM, strength, etc.			
Spine			
Shoulder			
Elbow			
Wrist			
Hand			
Hip and Pelvis			
Knee			
Ankle			
Foot			

- Is this individual currently under treatment for any medical or emotional condition? YES  NO 
  - If **YES**, please specify: \_\_\_\_\_
- Do you have any recommendations regarding the care of this individual? YES  NO 
  - If **YES**, please specify: \_\_\_\_\_
- Does this individual have sickle cell trait or disease? YES  NO
- **RECOMMENDATION FOR PHYSICAL ACTIVITY:** Unlimited \_\_\_\_\_ Limited \_\_\_\_\_
  - If **LIMITED**, please specify: \_\_\_\_\_

Health Care Provider's Signature: \_\_\_\_\_ Date Form Signed: \_\_\_\_\_

Health Care Provider's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_