Return this form (NO SUBSTITUITIONS) to:
Middlebury College Sports Medicine
Attn: Amal C. Duprey
219 South Main Street
Middlebury, VT 05753
T: *802-443-3636* ***F:*** *802-382-1899*

ATHLETE PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY A HEALTH CARE PROVIDER (not a family member) and SIGNED AT THE BOTTOM

Must be completed and returned within 6 months of start of first athletic season

Check box if you plan to participate in: ☐ Intercollegiate Sports ☐ Club Rugby ☐ Club Crew

Name: _____
LAST NAME FIRST NAME, MI

_____ Class of 20___ OR Class of 20___.5
DATE OF BIRTH MM/DD/YYYY

PHYSICAL EXAM:

B/P:	Pulse:	Ht:	Wt:	BMI:	(Corrected) Vision: L 20/ R 20/

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly arm span > height, myopia, VPS, aortic insufficiency)		
Eye/ears/nose/throat. *Pupils Equal *Hearing wnl		
Lymph nodes		
Heart -Murmurs (auscultation standing, supine, +/- Valsalva) -Location of PMI (Consider ECG, echo, and/or referral to cardiology for abnormal cardiac history or exam)		
Pulse - Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin - HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Back/Neck		
Shoulder/Arm/Elbow/Forearm/ Wrist/Hand/Fingers		
Knee/Hip/Thigh/Leg/Ankle/Foot/Toes		
Functional - Duck-walk, single leg hop		

OTHER HEALTH-RELATED ISSUES / UNDER TREATMENT FOR ANY MEDICAL OR PSYCHIATRIC CONDITIONS?

- PLEASE ATTACH COPIES OF ALLERGY AND ASTHMA ACTION PLANS FOR STUDENTS WITH ASTHMA / ALLERGIES, CRITICAL TEST RESULTS, OPERATIVE NOTES, AND CLEARANCE FOR ACTIVITY FROM SPECIALISTS FOR PRIOR CARDIAC, ORTHOPEDIC, OR OTHER MAJOR MEDICAL ISSUES.
- MENTAL HEALTH SERVICES FOR STUDENTS WITH EATING DISORDERS ARE LIMITED IN OUR REGION.

ADD / ADHD: Students taking medication for **ADD/ADHD** will **NOT** be able to obtain prescription refills from Parton Health Service. Make arrangements for refilling prescriptions directly with your patient.

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My medications, vitamins, herbals, and supplements. Include all **prescription** and **non-prescription** medications. ***Non-prescription medications may include vitamins, herbals, supplements, cold or cough medicines, aspirin, pain relievers, allergy relief medicines, antacids, laxatives, diet pills, and others that you do not need a prescription to buy.***

Prescription Medication		
Name (brand and generic)	**Dose**	**When, how, and how much I take** **Instructions**
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN

Over the Counter Medications and Supplements		
Name (brand and generic)	**Dose**	**When, how, and how much I take** **Instructions**
Ex. GNC Creatine Monohydrate	…	…
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN
		QD, BID, TID, QID, QHS, QAM, QPM, QOD, QH, Q2H, Q3H, PRN

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MIDDLEBURY COLLEGE
SICKLE CELL TRAIT STATUS VERIFICATION FORM

Following to be completed by Health Care Provider:

Results of Sickle Cell Trait Testing □ **HgbAS Positive** □ *HgbAS Negative*

Date of Sickle Cell Trait Testing: _____/_____/_____

I VERIFY THAT THE ABOVE-NAMED INDIVIDUAL HAS BEEN TESTED FOR THE SICKLE CELL TRAIT; AND

I VERIFY THAT I HAVE REVIEWED THIS PATIENT'S PERSONAL HEALTH HISTORY and COMPLETED THE PHYSICAL EXAM. (Please advise your patient about any concerns you have regarding clearance for athletic activities).

THE PATIENT IS:

_____ **CLEARED FOR ALL ACTIVITIES.** The patient is cleared for full athletic participation without restriction.

_____ **NOT CLEARED:**
□ pending further evaluation □ for any activities or athletics □ for certain activities /athletics

REASON:

_____

_____

RECOMMENDATION:

_____

_____

Healthcare Provider Name (Print): _____

Signature of Health Care Provider: _____

Address: _____

License #: _____ **Date of Exam:** _____/_____/_____

Phone: _____ **Fax:** _____

** Document will not be accepted if not signed and stamped **