Return this form 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 on Page 3
Must be completed and returned within 6 months of start of first athletic season
Check box if the patient plans 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 Health Services. Make arrangements for refilling prescriptions directly with your patient.

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Medications: Please list all current medications, including prescriptions, over the counter (OTC) drugs, vitamins, herbal remedies, and nutritional supplements. Include medications prescribed by primary care providers and specialists (including mental health).

Prescription Medication		
Name (brand and generic)	**Dose**	**When, how, and how much I take** **Instructions**

Over the Counter Medications and Supplements		
Name (brand and generic)	**Dose**	**When, how, and how much I take** **Instructions**
Ex. GNC Creatine Monohydrate	...	...

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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 for Not Cleared:

_____

_____

Recommendations for Clearance:

_____

_____

Healthcare Provider Name (Print): _____

Signature of Health Care Provider: _____

Address: _____

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

Phone: _____ **Fax:** _____