STUDENT NAME: ____ DOB: __________________

HEALTHCARE PROVIDER FORM

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

1. 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		

ANY 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 PRESCRIPTIONS FOR REFILLS FROM PARTON HEALTH SERVICE.PLEASE MAKE ARRANGEMENTS FOR REFILL PRESCRIPTIONS DIRECTLY WITH YOUR PATIENT**

FOR INTERCOLLEGIATE ATHLETICS, CLUB RUGBY, CLUB CREW-

NCAA REQUIREMENT SICKLE CELL TRAIT STATUS, HgbAS

Please check the appropriate box below and provide patient with a copy of either Newborn HgbAS screening result **OR** a recent HgbAS test result.

☐ **HgbAS Positive** ☐ **HgbAS Negative** ☐ **Declines HgbAS Test**

ACTIVITY CLEARANCE:

☐ **CLEARED FOR ALL ACTIVITIES.** I have reviewed this patient's personal health history and completed the physical exam. 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: ____

Please advise your patient about any concerns you have regarding clearance for athletic activities.

Healthcare Provider (print)______________________________ Phone:____________________ Fax:_________________

Address:____City: _________________State:_____ Zip:___________

Signature: ____Date of Exam: ___________________________

s robinson 3 31 22