MIDDLEBURY

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

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:** 802-443-2094*

Name: _____
LAST NAME, FIRST NAME, MI

_____ Class of 20___ ☐ *Check if coming in February*
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		

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 prescription refills from Parton Health Service. Make arrangements for refill prescriptions directly with your patient.

NCAA REQUIREMENT SICKLE CELL TRAIT STATUS, HgbAS: FOR INTERCOLLEGIATE ATHLETICS, CLUB RUGBY, CLUB CREW

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** ☐ **Date Lab Work Done: _____**

ACTIVITY CLEARANCE: *Please advise your patient about any concerns you have regarding clearance for athletic activities.*

☐ **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: _____

ProviderName(PRINT):_____
Phone: _____ Fax: _____
Address: _____
City, _____ State: _____ Zip: _____
Date of Exam: _____ Provider Signature: _____