PHYSICAL EXAMINATION FORM

Name ____ Date of birth ____________________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________________ Date ____________

Address ______________________________ Phone ____________

Signature of physician ______________________________, MD or DO

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HE0503 9-2681/0410

LAST NAME FIRST NAME MIDDLE INITIAL DOB (M / D / Y)

IMMUNIZATION RECORD – to be completed and signed by your health care provider

IT IS IMPERATIVE THAT YOU RECEIVE AND HAVE RECORDS OF REQUIRED IMMUNIZATIONS PRIOR TO COMING TO CAMPUS. THERE WILL BE A CHARGE FOR ANY IMMUNIZATIONS RECEIVED AT ETOWN STUDENT HEALTH.

REQUIRED IMMUNIZATIONS: (if waiving any immunizations, please visit Jayweb portal)

1. **MMR (Measles, Mumps, Rubella): 2 doses required**
   a. **Dose 1 given at age 12mo or later: ___/___/___**
   b. **Dose 2 given at least 28 days after first dose: ___/___/___**
2. **Tdap (Tetnus, Diphtheria, Pertussis): 1 dose within the past 10 years**
   a. **Tdap ___/___/___ (Boostrix or Adacel)**
3. **Hepatitis B Vaccine: 3 doses**
   a. **#1 ___/___/___; #2 ___/___/___; #3 ___/___/___**
4. **Completion date of Polio series: ___/___/___**
5. **Varicella (Chickenpox): 2 doses or history of chickenpox disease**
   a. **#1 ___/___/___; #2 ___/___/___**
   b. **OR history of disease date ___/___/___**
6. **Meningitis Conjugate/MCV Vaccine: REQUIRED by Pennsylvania State Law: #1 ___/___/___**
   a. **If 1st dose of meningitis vaccine was given before 16 years old, a booster dose is required #2 ___/___/___**

RECOMMENDED VACCINATIONS:

1. **Hepatitis A Vaccine: (2 doses) #1___/___/___ #2___/___/___**
2. **Human Papilloma Vaccine: (3 doses) #1___/___/___ #2___/___/___**
3. **Meningitis B Vaccine: (2 doses) #1___/___/___#2___/___/___ Type of vaccine: (circle) Bexsero OR Trumemba**
4. **Influenza Vaccine: (during flu season) ___/___/___**
5. **COVID Vaccine: Name of Vaccine________________________#1 ___/___/___; #2 ___/___/___**
6. **COVID Booster: Name of Booster________________________#1 ___/___/___**

SIGNATURE: ________________________ MD/DO/NP/PA DATE: ________________

(Signature acknowledges verification of immunization record)

ADDRESS: ________________________

____

____

PRINT LAST NAME: ________________________

PHONE: ________________________ FAX: ________________________