

PHYSICAL EXAMINATION

To be completed by health care provider. Exam must be within the past year.

Student Name(print) _____ Date of Birth _____

Date of exam	Temp	Pulse	BP	Ht.	Wt.
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Current Medications: _____

Check each item in proper column			
	Normal	Abnormal	Describe abnormalities
Head, ears, nose, throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatry			
Skin			

Medication Allergies: _____

Is student under treatment for any physical or mental health conditions? Yes No

If yes, please explain: _____

ATHLETES:

Does student have personal or family history of: Cardiac Hx (murmur, arrhythmia)? Yes No

Family Hx of nontraumatic sudden death before age 50? Yes No

Family Hx of Marfan Syndrome? Yes No

Prior Heat stress Hx? Yes No

Prior Exertional chest pain? Yes No

Pulmonary Hx (asthma, EIA, etc) Yes No

Head Injuries (number and severity)? Yes No

If yes to any of above, explain: _____

This student is medically cleared to participate in intercollegiate athletics: Yes No

List any limitations to performance: _____

REQUIRED FOR ADMISSION - Immunization History

Measles/Mumps/Rubella (MMR): 2 required: #1 _____ #2 _____ or copy of positive titer

Tet/Diph/Pert (Tdap): within last 10 years _____

Hepatitis B Series: #1 _____ #2 _____ #3 _____ or copy of positive titer

Varicella: (2 required): #1 _____ #2 _____ or copy of positive titer/date of disease

Meningococcal (MCV4): #1 _____ #2 _____

Polio: (date of completed primary series) _____

If high risk for TB; Tuberculin Skin Test: Date placed: _____ Date Read: _____ Result _____

or attach copy of Quantiferon test or chest X-ray

RECOMMENDED: Meningococcal B: #1 _____ #2 _____ Hepatitis A: #1 _____ #2 _____

COVID 19: #1 _____ #2 _____

Signature of Health Care Provider _____ Printed Name _____

Address: _____

WESTMINSTER COLLEGE

Wellness Center

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