

MOUNT VERNON NAZARENE UNIVERSITY

PHYSICAL EXAMINATION FORM

Name: (Last) _____ (First) _____ (Middle) _____

Height: _____ ft _____ in **Weight:** _____ pounds **Pulse:** _____ **BP:** _____ / _____

Vision Right 20/ _____ Left 20/ _____ **Corrected:** Yes or No (circle) **Pupils:** Equal or Unequal (circle)

	Normal	Abnormal Findings	Initials
MEDICAL	<input type="checkbox"/>		
Hearing	<input type="checkbox"/>		
Eyes/Ears/Nose/Throat	<input type="checkbox"/>		
Lymph Nodes	<input type="checkbox"/>		
Cardiovascular Screening	<input type="checkbox"/>		
Pulse	<input type="checkbox"/>		
Lungs	<input type="checkbox"/>		
Abdomen	<input type="checkbox"/>		
Genitalia (males only)	<input type="checkbox"/>		
Skin	<input type="checkbox"/>		

MUSCULOSKELETAL: (please list any previous injuries or current findings)

Neck	<input type="checkbox"/>
Shoulder/Arm	<input type="checkbox"/>
Wrist/Hand/Finger	<input type="checkbox"/>
Elbow/Forearm	<input type="checkbox"/>
Hip/Thigh	<input type="checkbox"/>
Knee	<input type="checkbox"/>
Leg/Ankle	<input type="checkbox"/>
Foot/Toes	<input type="checkbox"/>
Reflexes/Nervous System	<input type="checkbox"/>

Urinalysis: Sp. Grav. _____ Alb. _____ Sugar _____ Micro _____

Blood work required for Cross-Country athletes: (copy of results should be attached to physical form)

1. CBC with Iron Study
2. Ferritin Blood Test

CLEARANCE

- Cleared with no restrictions
- Cleared after completing evaluation / rehabilitation for: _____
- _____
- Not cleared for: _____
- Reason: _____
- _____

Recommendations: _____

I certify that I have on this date examined this student-athlete and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it inadvisable for this student to compete in athletic activities (note exceptions above).

 Examiner's Signature

 Date of Examination

 Examiner's Address (Including street address, city, state, zip code)

 Examiner's Name (Printed)

(_____) _____
 Examiner's Telephone Number

Examiner's Credentials (circle one): MD DO PA CNP

Have you ever had or have you now: (Place a check to left of each item)

Yes	No		Yes	No		Yes	No	
		Albumin in Urine			Fainting Spells			Pleurisy
		Arthritis			German Measles			Poliomyelitis
		Anemia			Hay Fever			Rectal Trouble
		Appendicitis			Headaches, Frequent			Rheumatic Fever
		Asthma			Heart Murmur			Scarlet Fever
		Back Trouble			Heart Trouble			Sickle Cell
		Bloody Urine			High Blood Pressure			Sinusitis
		Chickenpox			Histoplasmosis			Skin Disorder
		Chronic Cough			Infectious Hepatitis			Spitting Blood
		Convulsions			Infectious Mononucleosis			Tendency to Bleed
		Deafness			Jaundice			Thyroid Trouble
		Diabetes			Kidney Trouble			Tonsillitis
		Duodenal Ulcer			Measles			Tuberculosis
		Colitis			Meningitis			Venereal Disease
		Earache			Migraine			Whooping Cough
		Encephalitis			Mumps			Other Disorders

IMMUNIZATIONS (State Year Received)

Tetanus _____ Polio _____ Influenza _____

Others (Please list): _____

Other illnesses or complaints (list): _____

Injuries (broken bones, head, neck, and joint injuries, etc.): _____

Allergy to drugs, foods, plants, others: _____

Medications taken regularly: _____

Supplements/Vitamins taken regularly: _____

Absence of paired organ (kidney, eyes, reproductive organs, etc.): _____

Females Only:

Do you menstruate regularly? _____

Any trouble with your periods? _____

STUDENT INFORMATION

Student Name _____ Social Security # _____

Address _____ Cell Number _____

Father's Name _____ Mother's Name _____

Address _____

Phone Number _____

Father's Employer Name _____

Mother's Employer Name _____

Primary Physician's Name _____ Phone Number _____

Address _____

Parent (or Legal Guardian or Spouse) address:

Name _____ Relationship _____

Street _____

City _____ State _____ Zip _____

Emergency Phone _____ Business Phone _____

INSURANCE INFORMATION

Insurance Company Name _____

Address _____

Phone Number _____ Policy Holder's Date of Birth: _____

Policy Holder Name _____ Policy Holder's ID Number/SSN: _____

I certify that the foregoing information is true and correct.

Student's Signature _____ Date _____

Authorization to Release Information

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original.

Student's Signature _____ Date _____

PARENTAL PERMISSION (if under 18 years of age)

As parent or legal guardian of _____, I hereby give my consent for his/her practice and play in intramural or intercollegiate athletic events.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

I agree to the need for a screening medical examination and certify that the medical history below is accurate to the best of my knowledge.

Signature of Parent or Legal Guardian
(only if under age 18)