PHYSICAL EXAMINATION FORM

This form must be **completed and signed by a HEALTH CARE PROVIDER** (physician, nurse practitioner, or physician assistant), **NOT** a family member, **within one year prior to the first day of classes**.

STUDENT NAME:			STUDENT ID:		AGE:
DATE OF BIRTH:	ALLERGIES:		HEIGHT:	WEIGHT:	R.R.
UNCORRECTED VISION L 20/ R 20/ CORRECTED VISION L 20/ R 20/ O.U. 20/			TEMPERATURE:	B.P.	PULSE

Do you plan to participate in NCAA Intercollegiate Athletics at University of La Verne? YES NO
If so, what sport? _____

Subjective	

Objective	Normal	Abnormal	Description
Skin/Body marks			
Eyes			
Ears			
Nose			
Mouth, teeth, and throat			
Neck			
Chest/Lungs			
Heart			
Endocrine			
Abdomen			
Extremities			
Hip/Pelvis/Spine			
Neurological			

Assessment	

Plan	

Recommendations for intramural/Intercollegiate physical activity

- □ Without restrictions
- □ Should not participate in sports
- □ May participate with the following restrictions:_____
- □ Medical or orthopedic problem must be evaluated before participation is allowed

Medical provider signature: M.D. / N.P. / P.A.
Medical provider's printed name:
Physician's address:
Phone: Date of Examination:

Please return to: Student Health Services