Certificate of Medical Examination

To be completed by student and parent or guardian. Please print.
RETURN ENTIRE PACKET TOGETHER BY JULY 15 (fall admittance), **DECEMBER 1** (J Term admittance), **OR JANUARY 2** (spring admittance). Keep a copy for your records.
Questions? Call Perrella Health Center at 607-431-4120.

Mail to: Perrella Health Center, Hartwick College, P.O. Box 4020, Oneonta, NY 13820
Fax: 607-431-4124 | **e-mail:** healthcenter@hartwick.edu

Information on this form is confidential and solely for the use of the Health Center. No information will be released without the student's consent and it in no way will affect the student's college standing. The purpose of this form is to help the Health Center staff render the student effective aid and medical care.

Nursing Major ☐ Yes ☐ No   Intercollegiate Athlete ☐ Yes Sport(s) ______________________ ☐ No

Student name (last, first, middle) ______ Date of Birth ____/____/____ Student college ID # ______

Permanent home address (street, city, state, zip) ______

Home phone number ______ Parent cell phone number ______ Student cell phone number ______

Parent(s) or guardian(s) ______ In Case of Emergency, Contact ______

Address (street, city, state, zip) ______ Relationship ______

Phone number(s) ______ Phone number(s) ______

Health insurance company ______ Subscriber's name ______ Date of Birth ____/____/____

Insurance company address (street, city, state, zip) ______

Policy number ______ Group number ______

Contact your insurance company to verify coverage in the Oneonta area.

Does your insurance company require a student to get prior approval before obtaining services rendered outside the Perrella Wellness Center? ☐ Yes ☐ No

Health insurance is required for all full-time students. You must enroll in a policy made available by the College or waive the Hartwick insurance with proof of coverage. An on-line health insurance election form is available starting in June. It must be submitted electronically by all students.

Medical Treatment Permission Form

All registered students and parent/guardian of students under 18 years of age must sign.

I I hereby give permission to the Hartwick College medical/nursing staff to examine and treat the student named on this form for problems/injuries while a student at Hartwick College. In the event of time constraints, if unable to indicate consent, or if a minor parent/guardian is unable to be reached, I hereby give permission for the Perrella Staff to obtain consultative care that may include hospitalization, anesthesia, surgery, and/or other medical treatment. I understand that I have the right to revoke consent at any time. If I am enrolled in the nursing major, I authorize documentation regarding my annual physical, tuberculosis screening, and immunization status to be released to the nursing department and any clinical facilities where I will be a student.

Student signature ______ **Date** ____/____/____

Parent/guardian signature (if student under 18 years) ______ **Date** ____/____/____

Family and Student Medical History

To be completed by student and reviewed by health care provider.

_______________________ ____/____/____ __________
Student Name *Date of Birth* *Gender*

Family Medical History

If any of your immediate relatives have or have had the diseases listed, check the corresponding box (includes parents, grandparents, siblings, children).

☐ Alcoholism
☐ Anemia
☐ Bleeding tendency
☐ Cancer
☐ Death in family under 50
☐ Diabetes
☐ Heart disease
☐ Hereditary disorder
☐ High blood pressure
☐ Mental illness
☐ Migraines
☐ Obesity
☐ Stroke
☐ Tuberculosis
☐ None of the above

Student Medical History

Indicate past or present.

Intercollegiate athletes are required to complete pre-participation history form and physical exam form - see pages 7 and 8.

☐ ADD/ADHD
☐ Alcoholism
☐ Allergic rhinitis
☐ Anemia
☐ Aspergers/Autism
☐ Asthma
☐ Anxiety/panic attacks
☐ Bleeding trait
☐ Cancer or malignancy
☐ Chicken pox: date____/____/____
☐ Concussion: date____/____/____
date____/____/____
☐ Counseling for depression
☐ Diabetes
☐ Eating disorders
☐ History of heart disease/ heart problems
☐ Hypertension (elevated blood pressure)
☐ Infectious mononucleosis
☐ Inflammatory bowel disease
☐ Joint injury
☐ Migraines
☐ Pelvic infection
☐ Peptic ulcer
☐ Phlebitis
☐ Pregnancies/abortions
☐ Recurrent ear infections
☐ Recurrent throat infections
☐ Rheumatic fever
☐ Seizure disorders (epilepsy)
☐ Sexually transmitted disease
☐ Spine or neck injury
☐ Substance abuse
☐ Tuberculosis
☐ Urinary tract infections
☐ Viral hepatitis
☐ Other:____________________
____
____
☐ None of the above

☐ Covid 19: date of diagnosis ____/____/____ **Athletes MUST discuss positive diagnosis with Sports Medicine prior to arriving on campus.**

☐ Surgeries (please list)

____Date: ____/____/____

____Date: ____/____/____

☐ Present medications and dosage (Please list)

____

____

Medical indication for special dietary accommodations? ☐ Yes ☐ No

Specify:____

Contact Perrella Health Center at 607-431-4120 re: accommodations available.

Special academic accommodations needed? Please specify accommodations needed and contact the Center for Student Success at 607-431-4195 to establish your plan. ____

PLEASE INDICATE ANY ALLERGIES:

☐ No known medication allergies

☐ Medications (specify)____________________
☐ Environmental (specify)____________________
☐ Food (specify) ____________________
☐ Other (specify) ____________________

Physical Examination Form

Must be completed by physician, nurse practitioner, or physician's assistant. Please print.
RETURN ENTIRE PACKET TOGETHER BY JULY 15 (fall admittance), **DECEMBER 1** (J Term admittance), **OR JANUARY 2** (spring admittance). Keep a copy for your records.
Questions? Call Perrella Health Center at 607-431-4120.

Mail to: Perrella Health Center, Hartwick College, P.O. Box 4020, Oneonta, NY 13820
Fax: 607-431-4124 | **e-mail:** healthcenter@hartwick.edu

WE REQUIRE THAT THE PHYSICAL EXAMINATION BE COMPLETED WITHIN 12 MONTHS OF THE START OF THE ACADEMIC YEAR.
ATHLETE PHYSICALS MUST BE COMPLETED WITHIN 6 MONTHS OF FIRST PARTICIPATION.

______________________ Student name

____/____/____ Date of Birth

____/____/____ Date of Exam

Gender: ____________

Age: ____________

Blood pressure: ____________

Pulse: ____________

Height: ____________

Weight: ____________

Vision: ____________

Far: Right 20/ ____________

Corr. to 20/ ____________

Far: Left 20/ ____________

Corr. to 20/ ____________

Any operations, serious injuries, or serious illness not noted at right?

____

____

Clinical Evaluation	Normal	Abnormal	Please comment on all abnormal
1. Skin			
2. HEENT			
3. Lymphatic			
4. Respiratory			
5. Cardiovascular			
6. Musculoskeletal			
7. Hernia			
8. Abdomen			
9. GU			
10. GYN date last pap smear: ____/____/____			
11. Neurological			
12. Orthopaedic A. Shoulders	L ____ R ____	L ____ R ____	
B. Knees	L ____ R ____	L ____ R ____	
C. Ankles	L ____ R ____	L ____ R ____	
13. History of Covid 19	Date of diagnosis: ____/____/____		

Restrictions (specify):

____

____

By signing below I acknowledge review of the medical history pg 2 and completion of physical examination form. This student is able to engage in required physical education program and contact sports unless otherwise indicated. If a nursing major, student is medically cleared to wear respiratory protection and is in satisfactory condition to care for clients.

Name of healthcare provider (print) ____________ **Telephone** ____________

Address (street, city, state, zip) ____________

Signature of healthcare provider ____________ ____/____/____ **Date**

HARTWICK COLLEGE

Tuberculosis Risk Assessment

Must be completed by health care provider.

____ ____/____/____

Student Name *Date of Birth*

Clinicians should review and verify the information below. Persons for whom YES is answered in Part A are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. Per current CDC guidelines history of BCG vaccination is not a contraindication for a TST.

History of positive TST or IGRA blood test? (If yes, document in Part B) ☐ Yes ☐ No

History of BCG vaccination? (If yes, Consider IGRA if possible) ☐ Yes ☐ No

A: Required For ALL Students

- Has this student been in close contact with anyone with active TB? ☐ Yes ☐ No
- Was this student born in or has this student lived in or visited any countries that are **NOT** on the list below for more than one month?

  ☐ Yes ☐ No Country:______________________________
- Does the student have persistent cough with night sweats, loss of weight, fatigue, or fever? ☐ Yes ☐ No

If you answer yes to any of these questions, complete section B.

The countries listed below are without epidemic TB.

AMERICAN REGION: USA, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Costa Rica, Cuba, Jamaica, Saint Kitts and Nevis, Puerto Rico, Saint Lucia, Trinidad, Virgin Islands

EUROPEAN REGION: Albania, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom

WESTERN PACIFIC REGION: American Samoa, Australia, New Zealand

MIDDLE EAST REGION: Israel, Jordan, Lebanon, United Arab Emirates

If the student is from one of the above regions, skip Section B. If not, Section B must be completed.

B: Required For Any Students From Regions NOT Listed Above

Tuberculosis screening test (TST):
Must submit date placed, date read, and induration in mm even if 0. May submit attached copy of Quantiferon Gold blood test instead of TST.

Date placed ____/____/____

Date read ____/____/____

TST result: ______________mm

If TST (>/= 10 mm in most cases) or Quantiferon is positive, you must submit copy of CXR report.

- Treatment received for positive TST? ☐ Yes ☐ No
- Treatment was discussed and declined? ☐ Yes ☐ No

CXR result ______________ Date ____/____/____

Medication taken (if any) ______________

and dates taken: ____/____/____ to ____/____/____

Nursing majors must complete 2 step TST on pg. 5

____ ____/____/____

REQUIRED: Healthcare provider signature **Date**

____ ______________________

Address (street, city, state, zip) **Telephone**

HARTWICK COLLEGE

Immunization Record

Must be completed by health care provider, or attach official immunization record.

Student Name ______________________ Date of Birth ____/____/____

Required: Part I , A-E

A. M.M.R. (Measles, Mumps, Rubella) Two doses given after age 1-year required by NYS PHL 2165.

Dose 1: ____/____/____ Dose 2: ____/____/____
(minimum 28 days apart)

B. DPT (Diphtheria/Pertussis/Tetanus)

Series completed: ____/____/____
Booster—Tdap within last 10 years: ____/____/____

C. Polio: Completed primary series of polio immunization:

Type of vaccine: ______________________

Last booster: ____/____/____

D. Meningococcal tetravalent conjugate

BOOSTER DOSE REQUIRED WITHIN 5 YEARS OF START OF ACADEMIC YEAR.

(A.C.Y.W.) ☐ Menactra or ☐ Menveo

(Include all dates recieved)

Date: ____/____/____ Date: ____/____/____

E. SARS-CoV-2 (COVID-19)

Brand: ______________________

Date: ____/____/____ Date: ____/____/____

Date: ____/____/____

(Copy of vaccine card should be included with forms)

Recommended: Part 2

A. Hepatitis B

Dose 1: ____/____/____

Dose 2: ____/____/____

Dose 3: ____/____/____

B. Varicella (chicken pox)

Dose 1: ____/____/____ Dose 2: ____/____/____

OR date of disease: ____/____/____

C. Quadrivalent Human Papillomavirus vaccine (HPV)

Dose 1: ____/____/____

Dose 2: ____/____/____

Dose 3: ____/____/____

D. Meningitis B vacine (Bexsero or Trumenba)

Dose 1: ____/____/____ Dose 2: ____/____/____

Proof of immunity to measles, mumps, and rubella is required by NYS Health Law for all students registered for six or more credits. Medical exemptions are possible. Contact the Perrella Wellness Center at 607-431-4120 for questions or more information.

Proof of COVID-19 vaccination is required by Hartwick College. Requests for accommodation will be reviewed per the Covid 19 vaccination policy.

REQUIRED FOR NURSING MAJORS ONLY

A. Hepatitis B vaccine

Dose 1: ____/____/____

Dose 2: ____/____/____

Dose 3: ____/____/____

OR Positive titer date:

____/____/____

B. Varicella (chicken pox)
History of disease?
Yes, date required:

____/____/____

No, immunization dates:

Dose 1: ____/____/____

Dose 2: ____/____/____

OR Positive titer date:

____/____/____

C. Initial 2-step Tuberculosis screening test (TST)

(if first step negative, give second test 1-3 weeks later)

Step 1. TST date planted: ____/____/____ date read: ____/____/____

Results __________ mm induration ☐ Pos. ☐ Neg.

Step 2. TST date planted: ____/____/____ date read: ____/____/____

Results__________ mm induration ☐ Pos. ☐ Neg.

OR Quantiferon Gold: Results: __________ (attach copy of result)

If test is positive or there is a history of positive TST, chest x-ray is required.
Date: ____/____/____ Results: __________

Attach a copy of chest x-ray results. Attach plan for prophylactic therapy if chest x-ray is positive.

______________________ ____/____/____
REQUIRED: Healthcare provider signature — **Date**

______________________ ______________________
Address (street, city, state, zip) — **Telephone**

Meningococcal Vaccination Response Form

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to Hartwick College.

Check one box and sign below.

I have (for students under the age of 18: My child has):

☐ had meningococcal immunization within the past 5 years. The vaccine record is attached.

[*Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.*]

☐ read, or have had explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease **within 30 days** from my private health care provider or Hartwick College. (cost $120.00)

☐ read, or have had explained to me, the information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal disease.

☐ Completed the two dose series of Quadrivalent meningococcal vaccine. My last dose was greater than 5 years ago. I have read, or have had explained to me, the information regarding meningococcal disease. I understand the risks and I have decided that I (my child) **will decline** to recieve a booster dose of the immunization against meningococcal disease.

______________________________________ ____/____/____
Signed (by Student) OR (Parent/Guardian if student is a minor) **Date**

______________________________________ ____/____/____
Print Student's name (last, first, middle) **Student Date of Birth**

______________________________________ ______________________
Student email address **Student college ID #**

____
Student mailing address (street, city, state, zip)

____
Student phone number

Health Information Use and Disclosure

To be completed by student and parent or guardian.

____ ____/____/____
Student Name *Date of Birth*

This form authorizes the use and disclosure of individually identifiable health information to the Bassett Healthcare Network of Providers.

The Perrella Health Center at Hartwick College utilizes an electronic medical record-keeping system (EMR) in affiliation with the Bassett Healthcare Network. This system allows the Perrella Health Center and/or the Bassett Healthcare Network of Providers to access different components of any patient's "chart" and also provide up-to-date information to any provider in the Bassett Healthcare Network who might see patients on an emergency basis and/or when our clinic is closed. The Perrella Health Center also can promptly access test results as they are completed, bypassing clerical turnaround times. EMR is a welcome addition at the Perrella Health Center as we strive to provide efficient, comprehensive healthcare to our students.

1. I authorize the use and/or disclosure of my health information as described below.

2. My health information will be shared only between the Perrella Health Center and the Bassett Healthcare Network of Providers to facilitate continuity of care in the event I require treatment by the Fox Hospital Emergency Department or FoxNow walk-in clinic. It also will be available to Bassett Network affiliated specialists if I should require their services. This also will enable the Perrella Health Center to access my test results (laboratory tests, x-rays, cultures, etc.) in a timely manner in order to expedite my care.

3. I understand that the information in my health record may include information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services, reproductive health services, and treatment for sexually transmitted diseases.

   Note: Psychotherapy records from our College counselors, other than referrals to our providers, may be used/disclosed only pursuant to a separate signed authorization pertaining only to psychotherapy records.

4. I understand that the information I authorize to be used or disclosed may be used only within the Bassett Healthcare Network of providers, but may be subject to re-disclosure. Re-disclosure designates that the information is no longer protected under federal privacy regulations. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. I understand that this authorization is subject to revocation at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Perrella Health Center at Hartwick College. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the date of graduation or other official permanent separation from the College.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, but do acknowledge that by refusing to authorize, communication may be delayed. I understand that I need not sign this form to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided by the CFR 164.524. If I have any questions about disclosure of my health information, I can contact the director of the Perrella Health Center by calling 607-431-4120.

______________________	______________________	____/____/____
Student name (please print)	**Signature of student (or person authorized to consent for student)**	**Date signed**
______________________	______________________	____/____/____
Parent/guardian name if student is under 18 years of age (please print)	**Signature of Parent/guardian**	**Date signed**
______________________	______________________	____/____/____
Signature of staff person at Perrella Health Center	**Title**	**Date signed**

History Form | Intercollegiate Athletes Only

Date of exam must be kept within 12 calendar months to maintain eligibility.

Student Name ______________________ *Date of Exam* ____/____/____

Sport(s) ______________________ *DOB* ____/____/____ *Gender* ____________

Form must be completed and returned to Perrella Health Center at least 2 weeks prior to sports participation. NO EXCEPTIONS.

Questions? Call Perrella Wellness Center at: 607-431-4120 | Fax: 607-431-4124 | email: healthcenter@hartwick.edu

GENERAL QUESTIONS	Yes/No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐ ☐
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:	☐ ☐
3. Have you ever spent the night in the hospital?	☐ ☐
4. Have you ever had surgery?	☐ ☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes/No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	☐ ☐
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐ ☐
7. Does your heart ever race or skip beats (irregular beats) during exercise?	☐ ☐
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease ☐ Other: ____________	☐ ☐
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	☐ ☐
10. Do you get lightheaded or feel more short of breath than expected during exercise?	☐ ☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes/No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	☐ ☐
12. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?	☐ ☐
13. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	☐ ☐
14. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	☐ ☐
BONE AND JOINT QUESTIONS	**Yes/No**
15. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	☐ ☐
16. Have you ever had any broken or fractured bones or dislocated joints?	☐ ☐
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	☐ ☐
18. Have you ever had a stress fracture?	☐ ☐
19. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	☐ ☐
20. Do you regularly use a brace, orthotics, or other assistive device?	☐ ☐
21. Do you have a bone, muscle, or joint injury that bothers you?	☐ ☐

OTHER MEDICAL QUESTIONS	Yes/No
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐ ☐
23. Have you ever used an inhaler or taken asthma medicine?	☐ ☐
24. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐ ☐
25. Do you have groin pain or a painful bulge or hernia in the groin area?	☐ ☐
26. Have you had infectious mononucleosis (mono) within the last month?	☐ ☐
27. Do you have any rashes, pressure sores, or other skin problems? (i.e. MRSA)	☐ ☐
28. Have you ever had a head injury or concussion?	☐ ☐
29. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	☐ ☐
30. Do you have a history of seizure disorder?	☐ ☐
31. Do you have headaches with exercise?	☐ ☐
32. Have you ever become ill while exercising in the heat?	☐ ☐
33. Do you get frequent muscle cramps when exercising?	☐ ☐
34. Do you or someone in your family have sickle cell trait or disease?	☐ ☐
35. Have you had any problems with your eyes or vision?	☐ ☐
36. Have you had any eye injuries?	☐ ☐
37. Do you wear glasses or contact lenses?	☐ ☐
38. Are you trying to or has anyone recommended that you gain or lose weight?	☐ ☐
39. Are you on a special diet or do you avoid certain types of foods?	☐ ☐
40. Have you ever had an eating disorder?	☐ ☐

FEMALES ONLY

41. How many periods have you had in the last 12 months? ____________

MEDICINES AND ALLERGIES	Yes/No
Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.	
42. Do you have any allergies?	☐ ☐

If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens
☐ Food ☐ Stinging Insects

SARS-CoV-2 (COVID-19)

43. Have you had COVID-19?	☐ ☐
Date of diagnosis: ____/____/____	
Were you cleared for athletics post Covid 19?	☐ ☐

EXPLANATION AND DATES FOR ALL "YES" ANSWERS HERE ______________________

I hereby state that, to the best of my knowledge, the answers to the above questions are complete and correct. In signing this document, I give permission for my sports history and physical forms, updates regarding injury or illness, and information regarding my medical clearance for athletic participation may be shared with my coach, the athletic training staff, and the athletic administrative staff as deemed appropriate by the Perrella medical staff.

______________________ ____/____/____
Signature of athlete **Date**

______________________ ____/____/____
Signature of parent/guardian (if under 18) **Date**

Physical Examination Form | Intercollegiate Athletes Only

Must be completed by health care provider. **Date of exam must be kept within 12 calendar months to maintain eligibility. The initial exam must be completed within 6 months of first participation in athletics at Hartwick College.**

_______________________________ ____/____/____ ____/____/____
Student Name *Date of Birth* *Date of Exam*

The NCAA requires that a copy of the lab result from a Sickle Cell Solubility Test be provided with this form for every athlete

Form must be completed and returned to Perrella Health Center at least 2 weeks prior to sports participation. NO EXCEPTIONS.
Questions? Call Perrella Wellness Center at:607-431-4120 | Fax: 607-431-4124 | email: healthcenter@hartwick.edu

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		
Upper extremities		
Lower extremities		
Functional • Duck-walk, single leg hop		

SARS-CoV-2 (COVID-19)

Has this athlete been diagnosed with COVID-19? ☐ Yes ☐ No If yes, date of infection: _____/_____/_____

List any post diagnosis athletic clearance performed, with date(s): ______________________

Vital Signs/Visual Screen

Height ______________

Weight ______________

BP ________ / ________

(________ / ________)

Pulse ______________

Vision R 20/ ______________

L 20/ ______________

Corrected ☐ Yes ☐ No

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.

I have examined the above-named student, reviewed the History Form, and completed the preparticipation physical evaluation. This athlete is cleared to practice and participate in the sport(s) as outlined above without restriction **unless noted below**.

☐ 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 ______________________

____

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 healthcare provider (print or stamp) **Date**

______________________ ______________________
Address **Phone**

____
Signature of healthcare provider