



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 MM/DD/YY _____ 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) _____

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.

Yes! will have the Hartwick College Student Health Insurance Plan —OR—

Health insurance company _____ Subscriber's name _____ Subscriber's Date of Birth _____

Policy number _____ Group number _____

Medical Treatment Permission Form

All registered students must sign.

Parent/guardian of students under 18 years of age must sign.

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 MM/DD/YY _____

Parent/guardian signature (if student under 18 years) _____ Date MM/DD/YY _____



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 ____/____/____
- Covid 19: date of diagnosis ____/____/____
- 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

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:**
- Medications (specify) _____
 - No known medication allergies
 - Environmental (specify) _____
 - Food (specify) _____
 - Other (specify) _____



Physical Examination Form

Must be completed by physician, nurse practitioner, or physician's assistant. Please print.

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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 ____/____/____

Clinical Evaluation		Normal	Abnormal	Please comment on all abnormal
Gender: _____	1. Skin			
Age: _____	2. HEENT			
Blood pressure: _____	3. Lymphatic			
Pulse: _____	4. Respiratory			
Height: _____	5. Cardiovascular			
Weight: _____	6. Musculoskeletal			
Vision: _____	7. Hernia			
Far: Right 20/ _____	8. Abdomen			
Corr. to 20/ _____	9. GU			
Far: Left 20/ _____	10. GYN date last pap smear: ____/____/____			
Corr. to 20/ _____	11. Neurological			
Any operations, serious injuries, or serious illness not noted at right? _____ _____	12. Orthopaedic A. Shoulders	L _____ R _____	L _____ R _____	
	B. Knees	L _____ R _____	L _____ R _____	
	C. Ankles	L _____ R _____	L _____ R _____	
Restrictions (specify): _____	13. History of Covid 19	Date of diagnosis: ____/____/____		

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 ____/____/____

Student Name _____ Date of Birth ____/____/____

Clinicians should review and verify the information below.

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: _____
- ▶ Have you been a resident, volunteer, and/or employee of high-risk congregate settings Yes No
(e.g., correctional facilities, long-term care facilities, and homeless shelters)?
- ▶ Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease Yes No
(e.g., correctional facilities, long-term care facilities, and homeless shelters)?
- ▶ Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? Yes No
- ▶ Does the student have persistent cough with chest pain, hemoptysis, night sweats, loss of weight, fatigue, or fever? Yes No

If you answer yes to any of these questions, complete section B. A TB screening test is required.

The countries listed below are without epidemic TB. (World Health Organization Global Health Observatory, Tuberculosis Incidence 2020.)

AMERICAN REGION: USA, Antigua and Barbuda, Aruba, Bahamas, Barbados, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Costa Rica, Cuba, Curaçao, Grenada, Jamaica, Montserrat, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Sint Maarten (Dutch part), Trinidad and Tobago, Turks and Caicos Islands

EUROPEAN REGION: Albania, Andorra, Austria, Belgium, Croatia, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Luxembourg, Monaco, Montenegro, Netherlands, North Macedonia, Norway, Poland, Portugal, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom

WESTERN PACIFIC REGION: American Samoa, Australia, Cook Islands, Japan, New Caledonia, New Zealand, Samoa, Tonga, Wallis and Futuna Islands

MIDDLE EAST REGION: Bahrain, Egypt, Iran (Islamic Republic of), Israel, Jordan, Lebanon, Mauritius, Oman, Saudi Arabia, Seychelles, Syrian Arab Republic, Turkey, United Arab Emirates, West Bank and Gaza Strip

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

Quantiferon Gold blood test (IGRA) (preferred) (attach copy of lab results) — **OR** — **Tuberculosis screening test (TST)** :
Must submit date placed, date read, and induration in mm even if 0.

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.

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



Immunization Record

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

Student Name _____ Date of Birth ____/____/____

All dates should be written as MM/DD/YY

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: Yes No
Last dose: ____/____/____
- 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) or MenQuadfi
Date: ____/____/____ Date: ____/____/____

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.

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 vaccine (Bexsero or Trumenba)
Dose 1: ____/____/____ Dose 2: ____/____/____
- E.** SARS-CoV-2 (COVID-19)
Date: ____/____/____ (____) Date: ____/____/____ (____)
Date: ____/____/____ (____) Date: ____/____/____ (____)

List brand after each dose P - Pfizer, M - Moderna, J - Jansen, O - Other

REQUIRED FOR NURSING MAJORS ONLY

- A.** Hepatitis B vaccine
Dose 1: ____/____/____
Dose 2: ____/____/____
Dose 3: ____/____/____
OR Positive titer date: ____/____/____
 - B.** SARS-CoV-2 (COVID-19)
Dose 1: ____/____/____ (____)
Dose 2: ____/____/____ (____)
 - C.** Varicella (chicken pox)
History of disease?
Yes, date required: ____/____/____
No, immunization dates:
Dose 1: ____/____/____
Dose 2: ____/____/____
OR Positive titer date: ____/____/____
 - D.** 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 receive 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

Initial form must be completed within 6 months of first athletic participation date at Hartwick. This form and exam must be maintained within 12 calendar months to maintain athletic eligibility. To be completed by the student athlete.

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?	<input type="checkbox"/> <input type="checkbox"/>
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____	<input type="checkbox"/> <input type="checkbox"/>
3. Have you ever spent the night in the hospital?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you ever had surgery?	<input type="checkbox"/> <input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU	Yes/No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/> <input type="checkbox"/>
7. Does your heart ever race or skip beats (irregular beats) during exercise?	<input type="checkbox"/> <input type="checkbox"/>
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other: _____	<input type="checkbox"/> <input type="checkbox"/>

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	<input type="checkbox"/> <input type="checkbox"/>
10. Do you get lightheaded or feel more short of breath than expected during exercise?	<input type="checkbox"/> <input type="checkbox"/>

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)?	<input type="checkbox"/> <input type="checkbox"/>
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?	<input type="checkbox"/> <input type="checkbox"/>
13. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	<input type="checkbox"/> <input type="checkbox"/>
14. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	<input type="checkbox"/> <input type="checkbox"/>

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?	<input type="checkbox"/> <input type="checkbox"/>
16. Have you ever had any broken or fractured bones or dislocated joints?	<input type="checkbox"/> <input type="checkbox"/>
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	<input type="checkbox"/> <input type="checkbox"/>
18. Have you ever had a stress fracture?	<input type="checkbox"/> <input type="checkbox"/>
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)	<input type="checkbox"/> <input type="checkbox"/>
20. Do you regularly use a brace, orthotics, or other assistive device?	<input type="checkbox"/> <input type="checkbox"/>
21. Do you have a bone, muscle, or joint injury that bothers you?	<input type="checkbox"/> <input type="checkbox"/>

EXPLANATION AND DATES FOR ALL "YES" ANSWERS HERE _____

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

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?	<input type="checkbox"/> <input type="checkbox"/>
If yes, please identify specific allergy below. <input type="checkbox"/> Medicines <input type="checkbox"/> Pollens <input type="checkbox"/> Food <input type="checkbox"/> Stinging Insects	

SARS-CoV-2 (COVID-19)	
43. Have you had COVID-19? Date of diagnosis: ____/____/____ Were you cleared for athletics post Covid 19?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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. Athlete physicals must be completed within 6 months of the athlete's first participation at Hartwick College. Date of future exams must be kept within 12 calendar months to maintain eligibility

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

EXAMINATION

Height	Weight	BP	/	(/)	Pulse	
Vision R 20/	L 20/	Corrected	<input type="checkbox"/> Yes	<input type="checkbox"/> No				

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): _____

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 _____

PHYSICIAN REMINDERS

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