



Physical Examination Form

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

Questions? Call Perrella Health Center at 607-431-4120.

**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
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: ____/____/____		

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?

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 ____/____/____