



**State University of New York-Potsdam Sports Medicine
Physical Examination Form**

Directions to the Student- Athlete:

- 1) Please fully complete medical history questionnaire
- 2) Present questionnaire to physician or physician's staff
- 3) Return **both** questionnaire and physical exam record to sports medicine staff prior to participation

Directions to the Examining Physician:

- 1) Please review medical history questionnaire
- 2) Please complete and sign this physical exam form
- 3) Please clarify any abnormal findings and recommendations
- 4) Please return the completed form to the athlete

(PLEASE PRINT CLEARLY IN BLUE OR BLACK INK ONLY)

Name _____ Height _____ Weight _____

Sex Male Female Date of Birth (mm/dd/yy) _____ Sport(s) _____

Pulse _____ BP _____ / _____ Vision R 20/ _____ L 20/ _____ Corrected yes no

Health History

Please list the dates for these vaccinations:

Required:

MMR 1 _____

Required:

MMR 2 _____

Required:

PPD: _____

Date

Recommended:

Polio primary series completed _____

Recommended:

Menactra _____

Result

Recommended:

Hep B series completed #1 _____

#2 _____

#3 _____

Recommended:

Last Tetanus booster _____

List any medications you are currently taking including birth control and over the counter:

List any allergies: _____

Check and record date of any illness/condition you have had in the last 5 years:

Arthritis _____

Frost Bite _____

Heat Illness _____

Asthma _____

Hay Fever _____

Surgery _____

Concussions _____

Mononeucleosis _____

Hospitalization _____

Diabetes _____

Heart Problems _____

Tuberculosis _____

Epilepsy _____

Rheumatic Fever _____

Explain any current illness and/or medical limitations:

| Medical | Normal | Abnormal Findings |
|-------------------------|--------|-------------------|
| Appearance | | |
| EENT | | |
| Lymph Nodes | | |
| Heart/Cardiac Screening | | |
| Lungs | | |
| Abdomen | | |
| Genitalia | | |
| Skin | | |
| Neurological | | |
| Musculoskeletal | | |
| Neck | | |
| Back | | |
| Shoulder/Arm | | |
| Wrist/Hand | | |
| Hip/Thigh | | |
| Knee | | |
| Leg/Ankle | | |
| Foot/Toes | | |

Urinalysis:
(Optional)

USE THIS AREA TO EXPLAIN ANY ADDITIONAL HISTORY, ABNORMALITIES, AND/OR RECOMMENDATIONS:

TO THE PHYSICIAN: **By signing below, I signify that I have reviewed the athlete's medical history. Evidence of 2 Measles, Mumps and Rubella are required as well as a PPD within 1 year**

DO YOU HAVE ANY RECOMMENDATIONS REGARDING THE CARE OF THIS STUDENT WHILE ATTENDING THE UNIVERSITY? Yes _____ No _____

If yes, explain:

_____ **NO RESTRICTION for intercollegiate athletic participation**
OR
_____ **RESTRICTED PARTICIPATION to** _____

Physician's signature _____ DATE _____

Printed Physician's Name and Address _____

The athlete should return this to the address below. You cannot begin team activities until the sports medicine department has this on file.

Sports Medicine
Maxcy Hall/Athletics
44 Pierrepont Ave
Potsdam, NY 13676