

PHYSICAL EXAM (To be completed by a physician or a nurse practitioner/physicians assistant)

Name: _____ Date: _____ Age: _____ Date of Birth: _____

Address: _____ State: _____ Zip: _____

Height: _____ Vision: R: _____ / _____ corrected / uncorrected Glasses? Yes No

Weight: _____ L: _____ / _____ corrected / uncorrected Contacts? Yes No

Pulse: _____ Blood Pressure _____ / _____ Hearing: _____

	Normal	Abnormal	Comments
Eyes, Ears, Nose, Throat, Mouth & Teeth			
Neck, Thyroid			
Cardiovascular			
Chest & Lungs			
Abdomen			
Skin			
Genitalia-Hernia			
Testicular Exam			
Musculoskeletal: ROM, strength, etc.			
neck <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/>			
hands <input type="checkbox"/> back <input type="checkbox"/> hips <input type="checkbox"/>			
knees <input type="checkbox"/> feet <input type="checkbox"/> legs <input type="checkbox"/>			
Neurological			
Women only: (if available) Date of last gynecological exam:			
Pap smear date & result:			
Breast Exam			

BELOW IS MANDATORY ONLY FOR **INTERCOLLEGIATE ATHLETES** – MUST BE COMPLETED
 SICKLE CELL TRAIT: Positive _____ Negative _____ Unknown Status _____
 (must be screened or sign waiver)

- *Attach lab result of sickle cell trait screening (if available) or signed UNH Sickle Cell Waiver form
- *The NCAA encourages ALL Intercollegiate athletes to be aware of their sickle cell trait status
- *Waiver form available at: http://unhwildcats.com/Athletic_Training/Athletic_Training_home_page

- Have you discussed safer sex issues with this applicant? Yes No
- Does this applicant smoke cigarettes? Yes No If yes, have you discussed the risk? Yes No
- Has education about the use of alcohol, steroids, dietary supplements and other drugs been offered to this applicant? Yes No

Please comment on whether further evaluation or care is needed: _____

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

Recommendations for Physical Activity: Exercise programs & use of fitness equipment.
Unlimited Limited

Intercollegiate & Recreational Sports: Is this applicant capable of participating in a full program of college study, including participation in intercollegiate sports/intramural or club sports?
Yes No

Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Practitioner's Signature: _____ Date: _____

Please print name & address: _____

Telephone: _____

Return original to:
UNH Health Services
12 Ballard St.
Durham, NH 03824
Telephone: (603) 862-1530

If participating in Division I Intercollegiate Sports, please mail a copy of the physical assessment form to:
UNH Athletic Training
145 Main St., Field House
Durham, NH 03824

If participating in Club Sports, please mail a copy of the physical assessment form to:
Sport Club Coordinator
128 Main St., Hamel Center
Durham, NH 03824

STUDENT: I give consent for this form to be copied and released to the Athletic or Club Sports Department upon request. (Please complete in case permission is needed at a later date.)

Signature: _____ Date: _____