

PLEASE USE THIS FORM AND COMPLETE ALL QUESTIONS
BATES COLLEGE PHYSICAL EXAM FORM

To the examining physician: Please review the student's health history form and complete this physical examination form. We ask that you comment on all abnormalities. Examinations by physician parents or other relatives will not be accepted. All blanks must be filled in – including physician's signature, stamp & **date**. Failure to complete physical as requested will result in non clearance for sports participation **No Exceptions**. Please return to: The Health Center, Bates College, Lewiston, Me 04240 or fax to: (207)-786-8240. NCAA rule states physicals must be within 6 months of participation.

Last Name: _____ First: _____ M.I. _____
 Date of Birth: _____ Class: _____ Male _ Female _
 Home Address: _____ City _____ State _____ Zip Code _____
 Home Phone # : _____ Bates/cell #: _____
 Insurance Company Name: _____
 Policy Holder's Name: _____ Policy #: _____
 List all Sports at Bates: _____

Clinical Evaluation

D.O.B. _____	Height _____	Weight _____	Blood Pressure _____	Pulse _____	Normal/No	Abnormal/Yes
1. EENT.....					<input type="checkbox"/>	<input type="checkbox"/>
2. Thyroid.....					<input type="checkbox"/>	<input type="checkbox"/>
3. Chest and Lungs (Include Breasts).....					<input type="checkbox"/>	<input type="checkbox"/>
* 4. Heart (history of exercise-induced problems: fainting, irregular rate?).....					<input type="checkbox"/>	<input type="checkbox"/>
* 5. Heart Murmur ALL MURMURS MUST HAVE ECHO REPORT INCLUDED					<input type="checkbox"/>	<input type="checkbox"/>
6. GI (hernia, etc.).....					<input type="checkbox"/>	<input type="checkbox"/>
7. Endocrine system.....					<input type="checkbox"/>	<input type="checkbox"/>
8. Orthopedics.....					<input type="checkbox"/>	<input type="checkbox"/>
9. Current Orthopedic problems.....					<input type="checkbox"/>	<input type="checkbox"/>
10. Lymphatics/Hematology/Sickle Cell trait.....					<input type="checkbox"/>	<input type="checkbox"/>
11. Identifying body marks – scars, skin lesions.....					<input type="checkbox"/>	<input type="checkbox"/>
12. Neurologic.....					<input type="checkbox"/>	<input type="checkbox"/>
13. Genito Urinary (males include testicles).....					<input type="checkbox"/>	<input type="checkbox"/>
14. Is this student under treatment for any medical issues?.....					<input type="checkbox"/>	<input type="checkbox"/>
15. Is this student under treatment for any psychological issues?.....					<input type="checkbox"/>	<input type="checkbox"/>
16. Any medication or therapy?.please list					<input type="checkbox"/>	<input type="checkbox"/>
17. Are there any dietary restrictions?.....					<input type="checkbox"/>	<input type="checkbox"/>
18. History of eating disorders/concerns?.....					<input type="checkbox"/>	<input type="checkbox"/>
* 19. Are there any restrictions on physical activity?.....					<input type="checkbox"/>	<input type="checkbox"/>
* 20. Are there any sports this student is unable to participate in?.....					<input type="checkbox"/>	<input type="checkbox"/>
21. Allergies.....					<input type="checkbox"/>	<input type="checkbox"/>

22. How long have you known this student?.....
***FOR ALL SPORTS PHYSICALS:** Please write on the back of this form pertinent health history including major illnesses, hospitalizations, surgeries, traumatic head injuries, orthopedic injuries, and cardiac problems. For serious injuries or illnesses within the past year, please include any restrictions and a note of clearance to play sports. (First year students playing sports – please use separate sheet if needed.)

Signature of physician	Address	Telephone (include area code)	DATE
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Release of Information

I _____ hereby authorize and request that the Bates College Health Center and Bates College SportsMedicine be permitted to verbally communicate, send, and receive medical information, obtained in the course of treatment for injury or illness which is relevant to my participation in athletic activities, and includes my Complete Physical Exam form required for athletic participation.

Student Signature _____ **Date** _____

First Year Students Only: Please complete **immunization** information on the other side

*******Required***** Physician stamp with address here:**