*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 siblings 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: _____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 | Abnormal |
|---|---|---|
| 1. EENT…… | ☐ | ☐ |
| 2. Thyroid…… | ☐ | ☐ |
| 3. Chest and Lungs (Include Breasts)……..…… | ☐ | ☐ |
| * 4. Heart (history of exercise-induced problems: fainting, irregular rate?..... | ☐ | ☐ |
| * 5. Heart Murmur (include details and restrictions)……..... | ☐ | ☐ |
| 6. GI (hernia, etc.)…… | ☐ | ☐ |
| 7. Endocrine system…….... | ☐ | ☐ |
| 8. Orthopedics…….. | ☐ | ☐ |
| 9. Current Orthopedic problems..…….. | ☐ | ☐ |
| 10. Lymphatics……..... | ☐ | ☐ |
| 11. Identifying body marks – scars, skin lesions…….. | ☐ | ☐ |
| 12. Neurologic…….. | ☐ | ☐ |
| 13. Genito Urinary (males include testicles)…… | ☐ | ☐ |

| | NO | YES |
|---|---|---|
| 14. Is this student under treatment for any medical issues?..... | ☐ | ☐ |
| 15. Is this student under treatment for any psychological issues?..... | ☐ | ☐ |
| 16. Any medication or therapy?.please list ..... | ☐ | ☐ |
| 17. Are there any dietary restrictions?..... | ☐ | ☐ |
| 18. History of eating disorders/concerns?..... | ☐ | ☐ |
| * 19. Are there any restrictions on physical activity?..... | ☐ | ☐ |
| * 20. Are there any sports this student is unable to participate in?..... | ☐ | ☐ |
| 21. Allergies……..…… | ☐ | ☐ |

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**

_____

## 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

**Physician stamp with address here:**