ALL STUDENTS: A physical exam is required and must be within 12 months of the first day of class.
VARSITY ATHLETES: Per the NCAA Medical Handbook, a physical exam is required within 6 months of the start of fall practices. Exceptions to this date will not be considered.
The information on this form will be used by and accessible to Health & Counseling Services and Sports Medicine.

Student's Legal Name:_________________________________ **Preferred Name:** _______________ **DOB:**____________
Sex:__________ **Gender Identity :**__________ **Pronouns:**_______________ **Athletes – Sport:** ___________________

Exam Date: _____________ **Height:**________ **Weight:** ___________ **BMI:** ________ **B/P :** ________ **Pulse:**_______
Pupils: ❑Equal ❑Unequal **Vision: R 20/** _____ **L20/** _____ **Corrected:** ❑Yes ❑No

Physical Exam (Required)

	NORMAL	ABNORMAL FINDINGS
Skin		
Eyes/ears/hearing/nose/throat		
Lymphatics		

Cardiovascular: Heart rhythm ❑ Normal ❑Abnormal
- Heart murmur ❑No ❑Yes
  - Systolic murmur grade 3 or more ❑ Yes ❑ No Location_______________
  - Does murmur increase with Valsalva? ❑ Yes ❑No
  - Diastolic murmur ❑ Yes ❑ No Location_______________
- Delay in femoral pulses? ❑ Yes ❑No
- Marfan Criterias (Chest deformities, long arms and legs, wrist/joint hyperflexibility, flat footedness, scoliosis, lens dislocation, high arched palate, etc): ❑ Yes ❑No

Comments: ____

	NORMAL	ABNORMAL FINDINGS
Lungs		
Abdomen		
Genitourinary/Testicles		
Hernia		
Neurologic		
Emotional		

Musculoskeletal Exam (Required)

	NORMAL	ABNORMAL
Neck		
Back		
Shoulder/ arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee/Leg		
Ankle/foot/ toes		

Specify Abnormal Musculoskeletal Exam Findings:
____
____
____

Does the student…. (Attach a separate sheet if needed)	YES	NO	EXPLANATION
Take any medications? If yes, please list med, dose, frequency.			
Have any allergies (medicine, food, environmental)?			
Have a loss or seriously impaired function of any paired organ?			
Receive treatment for any medical or psychological condition?			
Do you have any general comments or recommendations regarding the care of this student, not previously addressed?			

TUBERCULOSIS RISK ASSESSMENT (At minimum: #1 and #2 MUST be answered; if "Yes" to either, #3 required)

1. **Does the student have signs or symptoms of active tuberculosis disease?** ☐ **Yes*** ☐ **No**
   ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production ❑ Coughing up blood ❑ Chest pain
   ❑ Loss of appetite ❑ Unexplained weight loss ❑ Night sweats ❑ Fever
   *Proceed with additional evaluation to exclude active TB disease, including tuberculin skin testing chest x-ray as indicted

2. **Is the student a member of a high-risk group or lived in/visited high-risk regions such as South America, Central America, Asia, parts of Europe, or Africa?** ☐ **Yes**** ☐ **No** (If no, PPD or IGRA testing not required)
   If Yes, PPD (Mantoux) **or IGRA test required. Consider IGRA, if possible, if history of BCG vaccination.

3. **Tuberculin Skin Test (PPD)** **Date given (within the 6 months of college entrance)** ___________________
   Date Read ______________**Result:** ___________ **(mm of induration)** ☐ **Positive** ☐ **Negative**

   Interferon Gamma Release Assay (IGRA) **Date obtained:**___________ **Specify method:** ☐**QFT-GIT** ☐**T-Spot**
   Result: ☐ **Positive** ☐ **Negative** ☐ **Indeterminant** ☐**Borderline (T-Spot only)**

4. **CHEST X-RAY REQUIRED if tuberculin skin test or IGRA is positive.** **Chest X-Ray result:** ☐ **Normal** ☐ **Abnormal**
   X-ray Date: _______________ **Treatment and Date Started:**_______________________________________

Clearance for Varsity Sports

❑Cleared without restriction
❑Cleared with restriction. Specify:____
❑Not Cleared. Reason:____

Date: _________ **Health Care Provider Signature:**_________________________________
Health Care Provider Name______________________________________**Telephone:** _______________

Muhlenberg College

Only <u>Varsity Athletes</u> should complete this page.

Student's Legal Name:___________________________________**Preferred Name:** _______________**DOB:**______________

Health Care Provider: COMPLETE FOR VARSITY ATHLETES ONLY

Sickle Cell Trait Status Physician Verification

NCAA requires confirmation of sickle cell trait status for all Division III athletes or signed waiver

❑I verify that the above named individual has been tested for sickle cell trait.

Date of Sickle Cell Trait Testing __________________

Results: ❑Positive ❑Negative

❑Student declined sickle cell trait testing.

Electrocardiogram

12-lead Resting ECG/EKG Required. Please attach interpretable copy of ECG.

❑Copy of ECG given to student.

Date: _________ **Health Care Provider Signature:**____

Health Care Provider Name & Address: ____

Provider Telephone Number: ___________________________ **Provider Fax:**_______________________________