Muhlenberg College

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

Student's Legal Name:_____**Preferred Name:** _____**DOB:**_____
Sex assigned at birth:_____ **Gender Identity:**_____**Pronouns:**_____ **Athletes – Sport:** _____

Section I: Physical Exam (Required)

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

Physical Exam	NORMAL	ABNORMAL FINDINGS
Skin		
Eyes/ears/hearing/nose/throat		
Lungs		

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: _____		

Abdomen		
Genitourinary/Testicles/ Hernia		
Musculoskeletal		
Neurologic		
Emotional		

Musculoskeletal (Required for Varsity Athletes)	NORMAL	ABNORMAL
Neck		
Back		
Shoulder/ arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee/Leg		
Ankle/foot/ toes		

Specify Abnormal Musculoskeletal Exam Findings:
_____
_____

Section II: Health History (Required)

DOES THE STUDENT... (Attach 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?			

Section III: Tuberculosis Risk Assessment (Required) #1 and #2 MUST be answered; if "Yes", need IGRA or PPD

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 to #1 or #2 , IGRA or PPD (Mantoux) test required. Must complete below.**
Interferon Gamma Release Assay (IGRA) Date obtained:_____ Specify method: ☐QFT-GIT ☐T-Spot
Result: ☐ Positive ☐ Negative ☐ Indeterminant ☐Borderline (T-Spot only)

Tuberculin Skin Test (PPD) Date given (within the 6 months of college entrance) _____
Date Read _____Result: _____ (mm of induration) ☐ Positive ☐ Negative

CHEST X-RAY REQUIRED (if tuberculin skin test or IGRA is positive). X-Ray result: ☐ Normal ☐ Abnormal Date: _____
Treatment (Include treatment and dates)_____

Clearance for Varsity Sports

❑Cleared without restriction
❑Cleared with restriction. Specify:_____
❑Not Cleared. Include reason:_____

Date: _____ **Health Care Provider Signature:**_____
Health Care Provider Name_____**Telephone:** _____

Muhlenberg College

Only Varsity Athletes 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.

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

Date of Sickle Cell Trait Testing _____

Results: ❑Positive ❑Negative

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:**_____