Student Name: _____ **DOB:** _____ **Banner #:** _____

SUNY BROCKPORT

Student Health Center, Hazen Hall
Ph: (585) 395-2414 Fax: (585) 395-2559

PHYSICAL EXAMINATION

Required by the NCAA for all new athletes—Recommended for all other students

TO THE LICENSED HEALTH PROFESSIONAL (D.O., M.D., P.A., N.P.) PERFORMING THIS EVALUATION:

Please complete the physical examination, comment on all positive findings and provide additional details as needed.

Height: ____ inches Weight: ____ lbs. BMI: _____ BP: _____ Pulse: _____ Vision: Right 20/___ Left 20/___

Hearing: Right: ____ Left: ____ Glasses? ____ Contacts? ____ Dental Appliance: YES NO Type: _____

*Date of Sickle Cell Solubility Test: _____ Result: _____

* ***REQUIRED*** *by the NCAA for* ***ALL*** *Student-Athletes regardless of ethnicity, family history, etc.*

HISTORY: To your knowledge does the student have any history of the following:

	Yes	No	Explanation
Arrhythmias/Murmurs			
Chest Pain			
Dyspnea on Exertion			
Shortness of Breath			
Family History of Heart Disease			
Syncope/Fainting			

Medical History: Are there any conditions of which we should be aware (such as single organs, hematologic disorder, seizure disorder, drug allergies, recent surgery, recurrent infections)? Describe fully. Use additional sheet if necessary.

_____

_____

PHYSICAL EXAM:	Normal	Abnormal	Explanation
HEENT			
Neck/Thyroid			
Lungs/Chest			
Cardiovascular			
Abdomen/Testicles			
Musculoskeletal/Spine			
Extremities			
Skin			
Neurologic/Psychiatric			

PROVIDER INFORMATION: Date of Exam: _____ *(Per NCAA, this exam must be completed no sooner than 6 months prior to the start of the sport.)*

I have reviewed the information above and make the following recommendations for his/her participation in athletics:

❑ **Cleared** ❑ **Not Cleared** ❑ **Cleared—f/u needed** ***(explain below)***

F/U Recommendations: _____

I have conducted a physical examination of this patient. All medical/psychiatric conditions and therapies are noted above or on attached pages.

Healthcare Provider Name: _____
Print or Stamp

Address: _____
(Street) (City) (State) (Zip)

Phone: (____)_____ Fax: (____)_____

Healthcare Provider Signature: _____ Date form completed: _____

14-4990

updated 05/2022