Physical Examination Form

This form must be submitted by **JULY 1ST** to Coe College Health Services,
1220 First Ave. NE, Cedar Rapids, IA 52402 Phone: 319-399-8617 Fax: 319-399-8269.
Forms may be scanned and emailed to **o-healthservices@coe.edu**
Student Athletes will not be allowed to practice without a physical on file in Health Services.

Physical Examination

Physical Exam must be completed by your health care provider
Must be completed 12 months prior to College Entrance (6 months for athletes)

Student's Name_____ Birth Date_____Gender Male_____/Female_____

Temp_____ Height_____ Weight_____ Heart Rate/Pulse_____ RR_____ BP _____/_____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal_____ Unequal_____

Hearing: R_____ L_____ Dental Care Needed: Y N Hgb/Hct_____

UA_____ Urine Protein_____ Urine Sugar_____

Exam	Normal	Abnormal	(please check normal or abnormal. No mark= no exam)
1. General Appearance	☐	☐	_____
2. Skin	☐	☐	_____
3. Head/Face	☐	☐	_____
4. Eyes	☐	☐	_____
5. Ears	☐	☐	_____
6. Nose & Sinuses	☐	☐	_____
7. Mouth/Throat	☐	☐	_____
8. Neck	☐	☐	_____
9. Thorax	☐	☐	_____
10. Breasts	☐	☐	_____
11. Lungs	☐	☐	_____
12. Heart	☐	☐	_____
13. Abdomen	☐	☐	_____
14. Genitalia	☐	☐	_____
15. Rectal	☐	☐	_____
16. Musculoskeletal	☐	☐	_____
17. Lymphatics	☐	☐	_____
18. Blood Vessels	☐	☐	_____
19. Neurological	☐	☐	_____
20. Psychological	☐	☐	_____
21. Depression	☐	☐	_____
22. Anxiety	☐	☐	_____
23. Eating disorder	☐	☐	_____

24. Student Athlete's only—Sickle Cell trait status: unknown ☐ positive ☐ negative ☐

- Current medications:_____
- Is the student currently being treated for an emotional disorder? If Yes please explain _____
  _____
- Recommendations for treatment, restriction of academic load or physical activity. Please indicate period of time for restriction and comments on history:_____
  _____
  _____
  _____

Are you this student's regular healthcare provider? Yes____ No____

CLEARANCE FOR ATHLETICS:

_____Cleared

_____Cleared after completing evaluation/rehabilitation for: _____

_____Not Cleared for: _____ Reason: _____

Name (print)_____ Signature_____ Date_____
Phone_____ Fax _____
Address_____
City State Zip

I give Coe College Health Services permission to release copies of this form to the Athletic Department and/or the Nursing Department at Coe College.

Student Signature_____Date _____