



Bridgewater State
Physical Exam/Medical Evaluation

Phone: (508)531-2044 Fax: (508)531-1447

Student's name: _____	Date of Exam: _____
D.O.B. _____	SS#: _____ Sport: _____

The physical Exam/Medical Evaluation must be completed by one of the following health care providers (MD, DO, NP, or PA)

Height: _____	Weight: _____	BP: _____	HR: _____
Lungs: B/L CTA: _____	Heart: RRR w/out m: _____		
Laboratory tests: (Hgb/HCT and UA are preferred, but not required)			
Confirmation of Sickle Cell Trait status as recommended by NCAA: <input type="checkbox"/> Positive <input type="checkbox"/> Negative			
Hgb or HCT: _____	Urinalysis: glucose: _____	protein: _____	blood: _____ other: _____

VISION:	RIGHT:	LEFT:
Uncorrected:	20/	20/
Corrected:	20/	20/
Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Physical Examination:	Normal:	Abnormal:	Describe Abnormalities:
1. Skin/Lymph nodes:			
2. Head/Neck/Thyroid:			
3. Eyes:			
4. Ears/Hearing:			
5. Nose/Sinuses/Throat:			
6. Mouth/Teeth/Gingiva:			
7. Lungs/Chest:			
8. Heart/Cardiovascular:			
9. Abdomen:			
10. Genitalia/Hernia:			
11. Neurological:			
12. Musculoskeletal:			
a. Spine			
b. Shoulder			
c. Elbow			
d. Wrist/Hand			
e. Hip/Pelvis/thigh			
f. Knee			
g. Ankle/leg			
h. foot			

Is the individual currently under treatment for any medical or emotional condition? Yes No

If yes, please specify: _____ *

*Diagnostic documentation is required if a student is taking a medication that is an NCAA banned substance (such as adderol or Ritalin)

Recommendations for Physical Activity in competitive sports: NO Restrictions Restrictions

If restricted, please specify limitations: _____

Health Care Providers signature _____ Date: _____

Health Care Providers printed name:	_____
Address:	_____
Phone number:	_____