Anna Maria College
Health Services
50 Sunset Lane, Paxton, MA 01612
Phone: 508-849-3315
Email: healthservices@annamaria.edu

PHYSICAL EXAMINATION FORM

You may use this form or submit a physical exam form from your healthcare provider.
MUST be dated within one year of college entrance, six months for athletes

Anna Maria College Student ID#_____ **Date of Exam: _____**

Student/Patient Information (please print)

Legal Name		Preferred Name	
Date of Birth	Sex at Birth M F Intersex Other	Gender	Pronouns

The above student has been accepted to Anna Maria College. The information provided will not affect their acceptance or academic status and will be used only as background for providing health care. Additional information/documentation may be included in attachments to this form as needed. No part of this medical record will be disclosed or released without written client permission.

Vitals – *must be completed* TB Risk Level: [ ] Low risk [ ] High risk

BP:	HR:	Weight (lbs):	Height (inches):	BMI:
Vision OD OS OU		Corrective lens use? [ ] Yes [ ] No	Hearing aids? [ ] Yes [ ] No	Other assistive devices? [ ] Yes [ ] No

	Normal	Abnormal Findings
Appearance	_____	_____
HEENT	_____	_____
Neck & Thyroid	_____	_____
Lymph Nodes	_____	_____
Cardiovascular	_____	_____
Lungs	_____	_____
Chest	_____	_____
Abdominal	_____	_____
Genitourinary	_____	_____
Musculoskeletal	_____	_____
Skin	_____	_____
Neurological	_____	_____
Psychological	_____	_____

Current Medications (include vitamins, contraceptives, inhalers)
_____
_____
Medication Allergies: _____
Food Allergies: _____
Reaction: _____
Does student carry an Epi Pen? [ ] Yes [ ] No

Does student have a history of concussion? [ ] Yes [ ] No
If Yes, how many? _____ Referred to Neurologist? _____
Cleared for high risk sports? [ ] Yes [ ] No

Has student been hospitalized in past year? [ ] Yes [ ] No

Does student have any past, current, or ongoing medical problems and/or mental health diagnoses? [ ] Yes [ ] No
If yes, please describe and include ongoing treatment plans:
_____
_____
_____

I hereby declare the above named student is medically cleared for general physical activity required to attend a post-secondary educational institution: [ ] Yes [ ] No
Student is fit to participate in intramural/club sports: [ ] Yes [ ] No
Student is fit to participate in NCAA Varsity Athletics: [ ] Yes [ ] No

Provider Signature: _____ Date: _____

Provider Name *(please print):*		
Street Address:		
City:	State:	Zip Code:
Phone:	Fax:	