

# BETHANY COLLEGE STUDENT HEALTH PHYSICAL EVALUATION

Health records are required for all Bethany College students

Please complete this form, **make a copy for your records**, and return to:

Health Services #59, Bethany College, 31 East Campus Drive, Bethany, WV 26032 or fax to 304-829-7471

THE FOLLOWING IS TO BE COMPLETED BY A PHYSICIAN or designee

NAME \_\_\_\_\_  MALE  FEMALE

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

**MEDICATION ALLERGIES** \_\_\_\_\_

**MEDICATIONS** \_\_\_\_\_

EYES \_\_\_\_\_ EARS \_\_\_\_\_

NOSE \_\_\_\_\_ THROAT \_\_\_\_\_

HEAD / NECK / SPINE \_\_\_\_\_

SKIN \_\_\_\_\_

CHEST \_\_\_\_\_

LUNGS \_\_\_\_\_

HEART \_\_\_\_\_

MURMURS \_\_\_\_\_

ABDOMEN \_\_\_\_\_

GENITALIA \_\_\_\_\_

EXTREMITIES \_\_\_\_\_

NEUROLOGICAL \_\_\_\_\_

**SIGNIFICANT PAST MEDICAL HISTORY** (Physical and emotional) \_\_\_\_\_

**RESTRICTIONS OR OTHER PERTINENT HEALTH INFORMATION** \_\_\_\_\_

**STUDENT IS CLEARED TO PARTICIPATE IN INTERCOLLEGIATE SPORTS**  YES  NO \*

\* If unable to clear, please give reason \_\_\_\_\_

Name of physician (print or type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Physician's (or designee) Signature \_\_\_\_\_

**Attach any significant medical history or pertinent information concerning this student.**