Questions or Comments?

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Email: hc-healthservices@haverford.edu

HAVERFORD COLLEGE
HEALTH SERVICES

Deadline for Submission:

August 1, 2024

PHYSICAL EXAMINATION

RETURNING VARSITY ATHLETE

Academic Year 2024-2025

- ☐ Information on this form is confidential and solely for the Health Services. PE form will not be released without the student's consent.
- ☐ Form must be uploaded to the HaverHealth Portal by August 1.
- ☐ This form can only be completed by a healthcare professional, *not a student or parent.*

Student's Legal Name:	Date of Birth:
Date of Physical Exam:	Student ID:
Sex assigned at birth (M, F, Intersex):	If applicable: ☐ MTF ☐ FTM

GENERAL MEDICAL INFORMATION

	Normal	Abnormal	Defer	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
Heart Rate: ( )				
Pulse Ox: ( )				
Blood Pressure: (/)				
Skin				
Eyes/Visual Acuity ☐ Corrected				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Psychiatric Currently under psychiatric care? ☐ **Yes*** ☐ No Psychiatric (Continued) Please check if applicable: ☐ Addiction ☐ **ADHD**** ☐ **Anxiety**** ☐ **Depression**** ☐ Eating Disorder ☐ Other:				*If yes, please provide office information below including phone and fax number. Include any psychiatric prescription renewal information. **Name: _____ **Phone: _____Fax: _____ **Please be aware that Health Services cannot initiate, adjust, or renew psychiatric medications. **Contact your PCP or psychiatrist now to initiate your mental health prescription **renewals**.
Other				

PATIENT NAME: _____

DOB: _____

MEDICATIONS – ATTACHED ADD'L DOCUMENTATION IF REQUIRED			
Medication Name	Dose	Instructions	Indication

ALLERGIES			
☐ Medication	☐ Environmental	☐ Food	☐ Stinging Insects
Does the student require an Epi Pen? ☐ Yes ☐ No			

PAST MEDICAL HISTORY

HOSPITALIZATIONS OR SURGERY IN PAST YEAR	
Date	Reason
Date	Reason

PHYSICAL ACTIVITY CLEARANCE ***REQUIRED***		
Can patient engage in varsity sports without restriction?	☐Yes	☐ No
If no, please specify recommendations for physical activity:		

Provider Name (Print Clearly):	
Provider Signature:	
Assessment Date:	
Practice Name/ Practice Stamp:	
Address:	
Phone:	
Fax:	

This completed exam form can be faxed to 833-846-6925.