**PE ON EVERY STUDENT***

**(WITHIN 1 YEAR FROM START OF SCHOOL)**

*****NCAA RULING - MANDATORY SPORTS PE ON ANY ATHLETE WITHIN 6 MONTHS FROM DATE OF 1ST SPORT TRYOUT*****

<table>
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<tr>
<th>BP</th>
<th>P</th>
<th>Weight</th>
<th>Height</th>
<th>BMI</th>
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Visual Acuity: R L With or without corrective lenses

MENTAL/EMOTIONAL STATUS

SKIN

HEENT

NECK, THYROID

LUNGS

CARDIO (Murmur, Pulses, Dysrhythmia)

Precordial auscultation – Supine/Standing

ABDOMEN

Femoral artery pulses

EXTREMITIES / SPINE

Musculoskeletal: ROM / strength / laxity

NEUROLOGICAL

UROGENITAL

Hernia (males) ANY IRREGULARITIES

LMP (females)

PERTINENT PAST MEDICAL HISTORY

CURRENT MEDICATIONS:

ALLERGIES TO MEDICINE / FOOD / OTHER?

HISTORY: Please circle if + Prior exertional chest pain, exertional syncope or / near syncope

Excessive, unexplained shortness of breath or fatigue with exercise

Prior history of heart murmur or increased blood pressure

Family history of premature death from cardiovascular disease in a relative younger than age 50 or unexplained sudden death.

Occurrence in family of hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome or Marfan’s syndrome YES or NO

*Sickle Cell trait

*REQUIRED FOR PARTICIPATION IN ANY NCAA VARSITY SPORT AS A FRESHMAN OR TRANSFER STUDENT

SPORTS INJURIES: Explain with dates

Concussion/Head Injuries/”Bellring”

Shoulders

Hips

Time missed

Elbows

Knees

Surgeries

Wrists

Ankles

Back

Hands

Feet

Neck

Fingers

Toes

ANY RESTRICTIONS ON SPORTS PARTICIPATION? Date of this exam

IMMUNIZATION HISTORY (with dates) ALL REQUIRED ON EVERY STUDENT / Provider please read! Some info not on your immunization sheets

Year of chickenpox disease Varivax

TB RISK (circle) Low or High: if high risk or international student REQUIRED Mantoux within 30 days from start of college.

Result mm. date If (+) CXR required result and treatment plan

POLIO (circle IPV or OPV)

TETANUS, Diphtheria, Pertussis series

Tdap

MMR

TENINGOCOCCAL MCV4

HEPATITIS B

OTHER: (Optional) – Hepatitis A, Gardasil, Pneumovax

Signature of provider

Date of this exam

Tel. Fax# Date of this exam

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