

**Mount Olive College Physical Examination
(Must be completed in English)**

Name: _____ **Academic year** _____
Date of Birth _____ **SS#** _____ **Sport** _____

- History:**
- a. Frequent Colds No/Yes: _____
 - b. Hay Fever No/Yes: _____
 - c. Allergies No/Yes: _____
 - d. Asthma No/Yes: _____
 - e. Diabetes/Thyroid/Endocrine No/Yes: _____
 - f. Serious Disease or Injury No/Yes: _____
 - i. Back No/Yes: _____
 - ii. Knee/Hip No/Yes: _____
 - iii. Foot/Ankle No/Yes: _____
 - iv. Hand/Wrist No/Yes: _____
 - v. Neck No/Yes: _____
 - g. Drugs or Medicine Regularly No/Yes: _____
 - h. As Needed Medications No/Yes: _____
 - i. Tuberculosis/Recent contact No/Yes: _____
 - j. Surgeries No/Yes: _____
 - k. Seizures No/Yes: _____
 - l. Hospitalizations No/Yes: _____

Physical Examination: Height _____ Weight _____ B/P _____ Pulse _____ Urinalysis: _____
SPGR _____ PRTN _____ GLUC _____ BLD _____ Other _____

Vision: Right _____ Left _____ Corrected _____ **PPD** or Chest X-ray and results (within past year)
Date: _____ Results: _____

- a. Ears, Eyes, Nose, Throat Normal/Abnormal: _____
- b. Thyroid/ lymph glands Normal/Abnormal: _____
- c. Chest Normal/Abnormal: _____
- d. Heart Normal/Abnormal: _____
- e. Lungs Normal/Abnormal: _____
- f. Abdomen Normal/Abnormal: _____
- g. Hernia Normal/Abnormal: _____
- h. Deformities Normal/Abnormal: _____
(circle and explain) Normal/Abnormal: _____
Head / Neck / Shoulder _____
Spine / Hip / Knee / Ankle _____
Elbow / Wrist / Hand _____

Do you know of any specific reasons why this student could not participate in physical education, intramurals, or athletics? No/Yes: _____

Has this Student experienced any emotional problems requiring assistance by a psychiatrist or counselor that might affect their adjustment to and performance at college? No/Yes: (if Yes, give name and address of Professional) _____

Additional Remarks: _____

Physician's name: _____ Signature: _____
Print or stamp

Address: _____ tele: _____

_____ Date: _____