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.