



WISCONSIN LUTHERAN COLLEGE

Physical Evaluation Form

PHYSICIAN SIGNATURE REQUIRED FOR STUDENT ATHLETES – NP or PA need MD or DO to provide a co-signature

Name: _____ Date of Birth: _____ Male: _____ Female: _____

Non-Student Athlete: _____ Student Athlete: _____ Team(s) _____

Sickle Cell Screening: The NCAA **requires** all freshmen and transfer student-athletes to confirm their sickle cell trait status prior to participation in any intercollegiate activity. Provider may attach a sickle cell screen, hemoglobinopathy evaluation, or hemoglobin electrophoresis results.

EXAMINATION		
Height: _____ Weight: _____ BP: _____ Heart Rate/Pulse: _____ Vision Corrected: _____ No _____ Yes R Eye: 20/____ L Eye: 20/____		
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		____ Marfan stigmata
Eyes/Ears/Nose/Throat		____ Pupils unequal
Neck		
Heart		____ Murmurs
Pulses		
Lungs		
Abdomen		
Genitourinary (males)		
Skin		____ HSV ____ lesions suggestive of MRSA ____ tinea corporis
Neurologic		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional = Duck-walk, Tip-toe walk, Single leg hop		

I have examined the above named student and completed the pre-activity physical evaluations. If conditions arise after the student has been cleared for participation, the physician or health care provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parent/guardian if applicable).

Exam Date: ____/____/____

____ Cleared for all sports/activities without restrictions

____ Not Cleared

____ Pending further evaluation ____ For any sports/activities ____ For certain sports/activities: _____

Reason: _____

Recommendations: _____

Clinic Address: _____ Phone: _____

Name & Credentials (print): _____ Signature: _____

Name & Credentials (print): _____ Co-Signature: _____

***Physician (MD/DO) signature required only for Student Athletes**

For Office Use Only

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