

WARTBURG PHYSICAL EXAMINATION FORM

(To be completed by Physician/Health Care Provider)

Date: _____

Name _____
(First) (Initial) (Last)

Birth Date _____ Male _____ Female _____

Blood Pressure _____/_____/_____ Pulse _____ Height _____ inches

Vision R20/_____/L20/_____/ Corrected: Y N Weight _____ pounds

Pupils – Equal _____ Unequal _____

Allergies: _____

Medical	Normal	Abnormal Findings
Appearance		
Eyes, Ears, Nose, Throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Neck		
Musculoskeletal		
Neck		
Back		
Shoulders/Arms		
Elbows/Forearms		
Wrists/hands/fingers		
Knees		
Legs/ankles		
Foot/toes		

REQUIRED IMMUNIZATIONS

(Below are requirements of Wartburg College)

Measles/Mumps/Rubella	Dates
<small>(2 MMRs required)</small>	
Dose #1 (month/day/year)	_____
Dose #2 (month/day/year)	_____

Chicken Pox/Varicella _____

Did student have disease? YES NO

Date of disease _____

Tetanus/Diphtheria _____

(Td or TDaP)

Polio (series, completed) _____

REQUIRED SCREENING

Tuberculin Skin Test – (PPD)

Given within the last year, one year prior to beginning of first term at Wartburg

Date/Time Given _____

Date/Time Read _____

Result: Negative Positive

Induration _____ mm

Recommended Immunizations

Meningococcal _____
(Meningitis)

Hepatitis A Dose #1 _____
Dose #2 _____

Hepatitis B Dose #1 _____
Dose #2 _____
Dose #3 _____

CLEARANCE FOR ATHLETIC PARTICIPATION AT WARTBURG

_____ Cleared for participation in _____
List sports

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not cleared for: _____ Reason: _____

HEALTH CARE PROVIDER (Signature Required)

Signature _____ Name (Print) _____

Clinic Name _____ Phone () _____ Fax () _____

Address _____
Street City State Zip Code