



Physical Exam

(To be completed by a physician or a nurse practitioner/physician's assistant)

Date of Exam: _____

Legal Name: _____ Preferred Name: _____

Preferred Pronouns: _____ Gender Assigned at Birth: _____

Current Gender Identity: _____ Date of Birth: _____ Age: _____

Address: _____ State: _____ Zip Code: _____

Height: _____ Weight: _____ Hearing: _____

Blood Pressure: _____ / _____ Pulse: _____ Glasses: Yes No | Contacts: Yes No

Vision: R Eye: 20/____ Corrected / Uncorrected | Vision: L Eye: 20/____ Corrected / Uncorrected

	Normal	Abnormal	Comments:
Appearance (Including Marfan Stigmata)			
Eyes, Ears, Nose, Throat, Mouth Teeth			
Neck, Thyroid			
Cardiovascular, Including Murmurs			
Chest & Lungs			
Abdomen			
Skin			
Genitalia – If Indicated			
Musculoskeletal: ROM, Strength, etc. <input type="checkbox"/> neck <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/> hands <input type="checkbox"/> back <input type="checkbox"/> hips <input type="checkbox"/> knees <input type="checkbox"/> feet <input type="checkbox"/> legs			

BELOW IS MANDATORY ONLY FOR **INTERCOLLEGIATE ATHLETES** – MUST BE COMPLETED

SICKLE CELL TRAIT: Positive ____ Negative ____ Unknown Status ____
(Must be screened or sign waiver)

*Attach lab result of sickle cell trait screening (if available) or signed UNH Sickle Cell Waiver form

*The NCAA encourages ALL Intercollegiate athletes to be aware of their sickle cell trait status

* Waiver form available at your Sportsware online page

- Have you discussed safer sex issues with this applicant? Yes No
- Has education about the use of alcohol, steroids, dietary supplements and other drugs been offered? Yes No
- Does this applicant smoke cigarettes or vape? Yes No If yes, have you discussed the risk? Yes No

Recommendations for Physical Activity	Exercise programs & use of fitness equipment	<input type="checkbox"/> Unlimited <input type="checkbox"/> Limited
Intercollegiate & Recreational Sports	Is this applicant capable of participating in a full program of college study, including participation in intercollegiate sports/intramural club sports	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please comment on whether further evaluation or care is needed: _____

Cleared after completing recommendation for evaluation / rehabilitation: _____

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s): _____

Health Clinician's Signature: _____ Date: _____

Clinician's Name & Address: _____

 Telephone: _____

Once Completed:

- Upload a copy to you UNH MyHealth&Wellness Portal
- Intercollegiate Athletes: Upload a copy of this physical to your Sportsware online page

Student-Athlete: I give consent for this form to be copied and release to the Athletic or Club Sports Department upon request. (Please complete in case permission is needed at a later date.)

Print Legal Name: _____

Athlete Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____
 (If athlete is not 18 years old)