Physical examination is to be completed by your Health Care Provider and is required within a year prior to arrival at Hamilton College.

Last Name First Name Sex at Birth DOB MM DD YYYY

Please review the student's history prior to completing the form below. Students are not eligible to participate in any Hamilton College sports programs, intercollegiate, intramural and club, until this form has been completed and submitted.

Students taking Medication for ADD/ADHD will not be able to obtain prescriptions for refills from the Johnson Center for Health and Wellness. Please make arrangements for refill prescriptions with your patient.

Height: _____ Weight (lbs.): _____ BMI: _____ Blood Pressure: _____/_____ Pulse: _____

Any allergies to medication(s) / food(s)? Please list: _____

System:	Normal / Abnormal.	Explain any abnormal findings:	System:	Normal / Abnormal	Explain any abnormal findings:
Skin	☐ ☐		Breasts	☐ ☐	
HEENT	☐ ☐		Abdomen	☐ ☐	
Neck/Thyroid	☐ ☐		Neurologic	☐ ☐	
Lymph Nodes	☐ ☐		Extremities/Joints	☐ ☐	
Cardiac	☐ ☐		Back	☐ ☐	
Lungs/Chest	☐ ☐		Genitourinary	☐ ☐	

Has student been fully vaccinated with a COVID vaccine? ___Yes ___No

Has student been previously diagnosed with COVID-19, MIS-C, and /or MIS-A? ___Yes ___No

Has student received monoclonal antibodies as therapy for COVID-19 infection? ___Yes ___No

If previously diagnosed with COVID-19 infection, including an asymptomatic case, have you been cleared by a medical provider to resume exercise and fully participate in **ALL** activities? ___Yes ___No/Explain: _____

Currently on any long term medications? ___No ___ Yes/What? _____

Has physical activity been restricted in the past 2 years? _____ No_____ Yes/Explain: _____

Recommendations for physical activity (PE, Intramurals, Club and Collegiate): _____Unlimited _____Limited, Explain: _____

Has student ever been treated for mental health or behavioral concerns? ____No ____Yes/Explain: _____

I certify that _____ has been under my care since _____.
(Student Name) (Date)

Health Care Provider Name (Please Print) _____ _____
Date of Exam: MM DD YYYY

Health Care Provider Signature: _____

Address _____ Phone: _____
or
Office Stamp _____ Fax: _____

Updated 6/1/2021