

# Physical Examination Report

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This form is to be completed and signed by your physician.

Return this form by June 15<sup>th</sup> to:  
 Rhodes College  
 Student Health Center  
 2000 N. Parkway  
 Memphis, TN 38112  
 Fax: 901-843-3134

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_/\_\_\_\_\_

### Assess the Following Systems:

	Normal	Abnormal	Explanation of Abnormality
Eyes			
Ears			
Nose			
Throat			
Mouth			
Dental			
Thyroid			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Skin			
Genitalia			
Menstrual History (if applicable)			
Hernia	No	Yes	
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

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## Please answer the following questions:

Do you consider this student physically and emotionally fit to undertake a college career? \_\_\_\_\_

If the student is unfit in any way, what restrictions or corrections would you advise? \_\_\_\_\_

Is the student able to participate in athletics or physical education? **Yes** or **No**

If the student is deemed unable, please explain why. \_\_\_\_\_

Examining Physician Name (Print) \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Examining Physician: \_\_\_\_\_ Date \_\_\_\_\_

**\*ALL FIRST YEAR VARSITY COLLEGIATE ATHLETES MUST HAVE AN EKG AND A SICKLE CELL SOLUBILITY TEST AS PART OF THEIR PHYSICAL.**

**PLEASE ATTACH A COPY OF THE EKG REPORT AND SICKLE CELL TEST RESULT WITH THIS PHYSICAL FORM.**

Examining Physician Name (Print) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Examining Physician \_\_\_\_\_ Date \_\_\_\_\_