UNIVERSITY OF NEW ENGLAND

Student Health Services
Biddeford Campus Portland Campus
P 207-602-2358 P 207-221-4242
F 207-602-5904 F 207-523-1913
Patient Portal
une.medicatconnect.com

PHYSICAL EXAMINATION FORM: Return by July 1st

- **This form must be completed by a healthcare provider, not a family member. Other physical exam forms will not be accepted.**
- ***Varsity and Rugby Club Athletes:*** *The entire form must be completed, including "Required Exam for Athletic Clearance" portion. Physical exam must be performed on or after April 1, 2022 per NCAA rules. Students missing these requirements will not be medically cleared to participate.*

Last Name:	**First:**	**M:**	**Sex assigned at birth:**	**Date of Birth:**
Medications: include dosage				
Allergies: Medications, Food, Material (latex)/Environmental and reactions:				
Past Medical/Surgical History: please specify				
Cardiac History: Has student ever been diagnosed with any cardiac condition? **If yes, please specify and include any documentation from cardiologist**				
BP (sitting)_____/_____ **Pulse**_____ **Ht** (in)_____ **Wt** (lbs)_____ **BMI** _____				

Systems		**Normal**	**Abnormal Findings**
Head, face, scalp and skull			
Nose and sinuses			
Mouth and throat (Include teeth & gingiva)			
Neck (Include thyroid)			
Ears			
Eyes			
Lungs			
Abdomen (Include hernia)			
G-U System			
Orthopedic			
Skin and lymph nodes (Lesions suggestive of MRSA)			
Neurological/Psychological			
Cardiac			
**** REQUIRED EXAM FOR ATHLETIC CLEARANCE - EACH BOX MUST BE CHECKED ****			
Precordial Auscultation	Supine		
Murmurs Detected?	Squatting		
	Standing		
	Standing w/ Valsalva		
Femoral and Radial Artery Pulses	*exclude coarctation*		
Physical Stigmata for Marfan Syndrome?			

___ **Cleared for all sports, activities, or program of study or travel abroad**

___ **Cleared with the following restrictions:** _____

___ **Student is NOT cleared**: _____

Is follow-up by a College practitioner indicated? _____

Physician's Signature_____ Date of exam:_____

Printed Name_____ Tel:_____

Address_____ Fax: _____

_____

Please include copy of immunization record