Baptist Bible College

Medical Examination—Physician

This must be completed and signed by the physician.

Name ______________________________ Exam Date* ______________________________

**If student is an athlete, exam date must be AFTER June 1.*

Birthdate ______________________________

Height ______________ Weight ______________ Blood pressure ______________

Heart rate ______________ Vision ______________ Need investigation ______________

Corrected: ☐ yes ☐ no

General Evaluation

Norm	Abnormal		*If Abnormal, please explain*
☐	☐	Head / scalp	
☐	☐	Neck	
☐	☐	Eyes / ears	
☐	☐	Nose / mouth / throat	
☐	☐	Heart	
☐	☐	Lungs	
☐	☐	Abdomen	
☐	☐	Skin	
☐	☐	Genitalia	
☐	☐	Hernia	
☐	☐	Arm / elbow / wrist	
☐	☐	Shoulders	
☐	☐	Hands / fingers	
☐	☐	Back / scoliosis	
☐	☐	Hips	
☐	☐	Legs / knee	
☐	☐	Calf	
☐	☐	Feet / ankles / toes	

Orthopedic/Flexibility Evaluation

Norm	Abnormal		*If Abnormal, please explain*
☐	☐	Spine ROM	
☐	☐	Shoulder	
☐	☐	Knee	
☐	☐	Ankle	
☐	☐	Hamstrings	

Immunizations

Please attach an immunization record to this form. This ***MUST BE INCLUDED****.*

Mumps/Measles/Rubella (MMR) *(2 doses required)*			
Hepatitis B *(3 doses required)*			
Hepatitis A *(not required)*			
Meningitis *(optional 1 dose)*			
Tetanus *(most recent)*			
Other			

Clearance for Athletic Participation

- ☐ Cleared—no restrictions
- ☐ With restrictions—cleared after completing evaluation and rehabilitation for ______________________________
- ☐ No clearance—Not cleared for ______________________________

Physician's Comments ______________________________

Physician signature ______________________________ Date __________

Physician name (print please) ______________________________

Address ______________________________

City / State / Zip ______________________________

Phone (______________)