TO THE EXAMINING PROVIDER: Please review the student’s history and complete this form. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his/her status. It will be used only as a background for providing health care. This information is strictly for the use of the Health/Counseling Services and will not be released without student consent.

________________________________________________  □ M  □ F

Last Name (Print)     First Name     Middle

Height ______ inches  Weight ______ lbs  BMI ______  BP ______  Pulse ______

Acuity (Recommended) with □ without □ correction  Right 20/  Left 20/

BMI ______  BP______  Pulse______  Hct/Hgb____________

Athletes (recommended)  Ferritin ______

Baseline peak flow (if any Hx of Asthma) __________________________

Urinalysis (Recommended)  Dipstick:  Glucose____  Blood____  Protein____  Bilirubin ______

Ketones_____  pH____  Leukocytes____

Examiner please note any deviations from normal, innocent or not (i.e. innocent heart murmurs/ varicocele, etc.) Anything not noted and found later will be assumed to be a new problem.

This will be considered a pre-sport participation physical.

Are there any abnormalities of the following systems?

<table>
<thead>
<tr>
<th>System</th>
<th>NO</th>
<th>YES</th>
<th>Describe fully</th>
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</thead>
<tbody>
<tr>
<td>HEENT</td>
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<tr>
<td>Respiratory</td>
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<td>Cardiovascular</td>
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<td>Gastrointestinal</td>
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<tr>
<td>Genitourinary (inc. hernia)</td>
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<td>Musculoskeletal</td>
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<td>Metabolic/Endocrine</td>
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<td>Neuropsychiatric</td>
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<tr>
<td>Skin</td>
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</tbody>
</table>

1. Is there loss or seriously impaired function of any organ?  Yes____  No____

2. Does student have physical appearance of Marfan’s syndrome?  Yes___  No____

3. Does the student plan on participating in an intercollegiate sport?  Yes____  No____

   Which sport(s)?  ____________________________________________

4. On the basis of this examination, I find this student medically suitable to participate in intercollegiate sport activity at Gettysburg College.  Yes____  No____

5. Do you have any recommendations regarding the care of this student?  Yes____  No____

   Explain:  ___________________________________________________

6. Is this patient now under treatment for any medical or emotional condition?  Yes____  No____

   Explain:  ___________________________________________________

Provider’s Signature__________________________  MD, DO, NP, PA

Print Last Name______________________ Date_______________

Return all information to:

Student Health Service
Gettysburg College
300 N. Washington St Box 436
Gettysburg, PA  17325  OR
Fax# 717-337-6978