

Athletics and Campus Recreation
300 North Washington Street
Campus Box 400
Gettysburg, PA 17325

Fax: (717) 337-8462

***NCAA Athletes or potential athletes complete form after May 1st**

TO THE EXAMINING PROVIDER: Please 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 Athletics Department and will not be released without student consent.

Gender _____

Last Name (Print) _____ First Name _____ Middle _____

Height _____ inches Weight _____ lbs BMI _____ BP _____ Pulse _____

Acuity: with ☐ without ☐ correction Right 20/ _____ Left 20/ _____

Athletes (recommended)
Hct/Hgb _____
Ferritin _____

TB SCREENING – MUST CHECK EITHER LOW OR HIGH RISK

☐ **Low Risk**

☐ **High Risk - If HIGH RISK student must have a TB skin test (Mantoux only) within the past 6 months**

Date of Test _____ Signature of Provider Testing _____

Date of Reading _____ ☐ Negative _____ mm ☐ Positive _____ mm

Signature of Provider Reading Test _____

If test Positive: QuantiFERON Gold Test Date _____ Results: ☐ Negative ☐ Positive Please attach results.

Any Treatment _____ Date of Treatment _____

Chest X-ray: Date _____ Result _____ INH Treatment: Date _____

Are there any abnormalities of the following systems?

	NO	YES	Describe fully
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary (inc. hernia)			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

1. Is there loss or seriously impaired function of any organ? Yes _____ No _____

2. Has the student had COVID-19? Yes _____ No _____ If Yes, Date: _____

3. Does student have physical appearance of Marfan's syndrome? Yes _____ No _____

4. Does the student plan on participating in an intercollegiate sport? Yes _____ No _____
Which sport(s)? _____

5. **On the basis of this examination, I find this student medically suitable to participate in intercollegiate sport activity at Gettysburg College.** Yes _____ No _____

6. Do you have any recommendations regarding the care of this student? Yes _____ No _____
Explain: _____

7. Is this patient now under treatment for any medical or emotional condition? Yes _____ No _____
Explain: _____

Date _____ Provider's Name _____ Provider's Signature _____

Address _____

Telephone: (_____) _____ Fax: (_____) _____

Student: Please upload this form to ARMS pending details