Athletics and Campus Recreation Fax: (717) 337-8462
300 North Washington Street
Campus Box 400
Gettysburg, PA 17325

***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_____

Athletes (recommended)
Hct/Hgb_____
Ferritin_____

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

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