

Albright College
Gable Health and Counseling Center/Department of Sports Medicine
13th & Bern Streets, P.O. Box 15234 Reading, PA 19612
 (610) 921-7532 FAX (610) 921-7590

TO THE HEALTH CARE PROVIDER: Please review the student's history and complete the provider's report. Please comment on all positive answers. 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 and mental health care. Physical Exam must be done within 1 year prior to college entrance.

LAST NAME (Print) _____ FIRST NAME _____ DOB: ____/____/____ SEX: M F

BP ____/____ P _____ Height _____ Weight _____

VISUAL ACUITY: R ____/____ L ____/____ Corrected: Y N

Current Medications and Dosage: _____

Normal

Abnormal – Please Describe

	Normal	Abnormal – Please Describe
Skin		
Head and Scalp		
Eyes		
Ears/Hearing		
Mouth, Nose, Throat		
Neck		
Heart		
Lungs		
Abdomen / Hernia		
Genitourinary		
Metabolic/Endocrine		
Musculoskeletal		
Neurologic		
Emotional		

- CLEARED** for full activity _____ (list sport)
- CLEARED**, with recommendation(s) for further evaluation or treatment for: _____
- NOT CLEARED** for the following types of sports (please check those that apply):
- COLLISION CONTACT NON-CONTACT STRENUOUS MODERATELY STRENUOUS NON-STRENUOUS

Is the patient currently under treatment for any medical or psychological condition? Yes ____ No ____

If yes, please explain:

Do you have any recommendations regarding the care of this student, not previously addressed? Yes ____ No ____

If yes, please explain:

Health Care Provider Signature _____ Health Care Provider Name (printed) _____

Address:

Provider Telephone Number: _____ Fax Number: _____ Date _____