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
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 _____**Printed Name** _____ (circle) MD, DO, CRNP, PA-C

Address / Office Stamp:

_____

Provider Telephone Number: _____ Fax Number: _____ Date _____