



## SWARTHMORE COLLEGE

### HEALTH EVALUATION (completed no sooner than 12 months prior to college entrance)

Patient's Name: \_\_\_\_\_ Patient's date of birth \_\_\_\_\_

Height: _____ Weight: _____	Amount of weight change in past year _____ gain or loss	Suspected or Confirmed Eating Disorder? Yes _____ No _____
BP: _____/_____	Pulse: _____	Gross Hearing: R _____ L _____
Vision (Uncorrected): R _____ L _____ (Corrected): R _____ L _____		

### CLINICAL EVALUATION

**Please attach any information or instructions to better assist the Health Center staff in this student's health care**

Physical Examination: (WNL, within normal limits)

Organ System	Findings	Remarks	
Eyes	WNL	Remarks	
Ears	WNL	Remarks	
Nose	WNL	Remarks	
Throat	WNL	Remarks	
Neck	WNL	Remarks	
Lungs	WNL	Remarks	
Heart	WNL	Remarks	
Abdomen	WNL	Remarks	
Lymph Glands	WNL	Remarks	
G.U.	WNL	Remarks	
Skin	WNL	Remarks	
Neuro	WNL	Remarks	
Musculoskeletal	WNL	Remarks	

Is student an athlete? Yes \_\_\_\_\_ No \_\_\_\_\_

**\*\*Mandatory Laboratory Testing for NCAA participating Athletes only**

Athlete Sickle Cell Screen Result \_\_\_\_\_ MD Signature \_\_\_\_\_

**Or: Waiver of sickle cell screen: If student waiving blood test, they understand that athletes with the sickle cell trait can collapse or even die during intense exercise. Knowing sickle cell status may prevent serious complications from sport participation. Waiving the test will not interfere with student's ability to play a sport.**

Signature of Student: \_\_\_\_\_ or Signature of Parent if student is under 18 years of age: \_\_\_\_\_

Is student able to participate in all physical activities and athletics? Yes \_\_\_\_\_ No ( If no, explain)

Summarize **medical** and **psychological** problems or suggestions for Student Health and Wellness Center

Health Care Provider Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

