# 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)

| | | | |
|---|---|---|---|
| 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 _____