PAUL SMITH'S COLLEGE

CLINICAL EVALUATION

(To be no older than 3 months prior to date of entry)

□ **Health History (back) reviewed with the patient to ensure completeness and accuracy.**

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____ Temp: _____

Vision: Uncorrected Corrected (Glasses or Contacts)
Right: 20/_____ 20/_____
Left: 20/_____ 20/_____

Hearing:
Right: _____ ○ Aid
Left: _____ ○Aid

General	Normal	Abnormal	Details
HEENT			
Heart			
Lungs & Chest			
Vascular System			
Abdomen			
Skin			
Upper Extremities			
Lower Extremities			
Spine & Musculoskeletal			
Neurologic			
Psychiatric			
Genitourinary			[ ] Not done
Anorectal			[ ] Not done

Does the student use tobacco product(s), alcohol, or illegal drugs?
If so, please specify type and quantity: _____

Does the student have a disability- physical or cognitive, which may require special arrangements?
If so, specify and send supportive documentation: _____

Please list current medications; specify condition being treated, dose/ frequency/route:
_____
_____

In your opinion, is this patient/student physically able to participate in intercollegiate athletics?
[ ] Yes [ ] No
If not or there is a limitation, please explain_____

In your opinion, is this patient/student able to meet the physical and emotional demands of college life?
[ ] Yes [ ] No
If not or there is a limitation, please explain: _____

Provider's Name: _____
Print

Provider's Signature: _____ Date: _____

Address: _____
Street City State Zip

Phone: (____) _____ Fax: (____) _____

Student Name: _____ DOB: _____