PHYSICAL FORM

Please give this form to your physician, nurse practitioner or physician's assistant.

This form will also serve as a pre-participation Sports Physical for incoming college athletes. A physical exam is mandatory for all incoming first year and transfer students. It must have been completed in the last 12 months. Student athletes must complete a physical each year.

Please scan and upload the physical form at **login.ic.edu** in the Chesley Health and Wellness App. Contact **217.245.3038** with any questions.

TO THE EXAMINING PROVIDER: Please complete and sign during the Physical Exam. This information is necessary for Illinois College to best serve this student.

Student's Name _____ DOB_____ ❑ Male ❑ Female ❑ Transgender
Last *First* *Middle*

Measurements:

Temp _____ Pulse _____ Resp _____ BP _____ Height _____ cms/inches Weight _____ kgs/lbs BMI _____

Visual Acuity: Uncorrected [ ] Right 20/ _____ Left 20/ _____ Corrected [ ] Right 20/ _____ Left 20/ _____

ATHLETES ONLY: Which sport? _____ Do you have sickle cell trait/disease*? ❑ Yes ❑ No (attach documentation)

**The NCAA mandates that all student athletes must submit their sickle cell results before any participation in intercollegiate sports. We are able to accept results from birth or new test results.*

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? Please describe fully. Use additional sheet if needed.

	Normal	Abnormal	Not Examined	Comments
General Appearance: Marfan stigmata, LOC, nutrition, development, mobility, affect, speech, hygiene				
Skin: rash, HSV, lesions suggestive of MRSA, color, tinea corporis, acne				
Head: shape, size, symmetry, scalp, TMJ, lesions, hair				
Eyes: Lids, conjunctiva, sclera				
Extraocular muscles				
Visual fields				
Pupils: size, reaction to light and accommodation				
Fundi				
Ears: pinna, canals, TMs, hearing				
Nose: patency, nares, sinuses, nasal mucosa, septum, turbinates				
Mouth: lips, gums, teeth, mucosa, palate, tongue				
Throat: pharynx, tonsils, uvula				
Neck: ROM, symmetry, palpation, thyroid, lymph nodes				
Breasts: size, symmetry, skin, nipples, palpation, nodes				
Chest/Lung: excursion, palpation, percussion, auscultation				
Cardiac: PMI, palpation, rate, rhythm, S1, S2, murmurs (standing, supine, +/- Valsalva), gallops, bruits, extra sounds				
Abdomen: appearance, bowel sounds, bruits, percussion, palpation, liver, spleen, flank, suprapubic, hernia				
Anorectal: perianal, digital rectal, stool guaiac				

Female Genitalia: Internal: vaginal mucosal, cervix				
Bimanual: vagina, cervix, uterus, adnexa				
Male Genitalia: penis, scrotum, testes, hernia				
Lymph Nodes: cervical, subclavian, axillary, inguinal, other				
Musculoskeletal: Back/Spine: ROM, palpation				
Upper Extremity: ROM, strength, palpation of shoulder/arm/elbow/ forearm/wrist/hand/fingers				
Lower Extremity: ROM, strength, palpation of hip/thigh/knee/leg/ankle/ foot/toes				
Functional: Duck-walk, single leg hop				
Peripheral Vascular: Upper Extremity: pulses, appearance, temp				
Lower Extremity: pulses, appearance, temp, simultaneious femoral and radial pulses				
Neurologic: cranial nerves, motor, sensory, cerebellar, reflexes, gait, mental status				

ASSESSMENT:

On the basis of this examination, I approve the student's participation in:

❑ Any intercollegiate sports for one year ❑ Yes ❑ No ❑ Limited

❑ Any physical education activity class with no restrictions

❑ An adapted physical education program to exclude the following activities: _____

❑ No physical education activity classes for the following reason(s): _____

TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

Have you ever had a positive TB skin test? ❑ Yes ❑ No

Have you ever been vaccinated with BCG? ❑ Yes ❑ No

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born or have lived outside of the U.S.? ❑ Yes ❑ No If yes, what country: _____

If the answer to any of these questions is yes, a Tuberculin Skin Test is required.

Tuberculin Skin Test Date given: ____/____/____ Date read: ____/____/____

Result:_____ (record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): ❑ Positive ❑ Negative

Interferon Gamma Release Assay (IGRA) Date Obtained: ____/____/____

(specify method) ❑ QFT-GIT ❑ T-Spot ❑ other

Result: ❑ Negative ❑ Positive ❑ Indeterminate ❑ Borderline (T-Spot only)

Chest X-ray (required if TST or IGRA or T-Spot is positive) Result: ❑ Normal ❑ Abnormal Date of chest x-ray: ____/____/____

HEALTH CARE PROVIDER CERTIFICATION

Health Care Provider (please print) _____

Health Care Provider's Signature _____ Date _____

Address _____

Telephone _____ Fax _____