

Return all information to:
 Illinois Wesleyan University
 Athletic Training
 PO Box 2900
 Bloomington, IL 61702

Illinois Wesleyan University Athletic Training
 Ph. (309) 556-3601 Fax (309) 556-3484

This form is due:
August 1 for Fall Semester
December 1 for Spring Semester and/or May Term

Applicants for admission are required to have the following exam completed no more than six (6) months prior to date of entry.

 Last Name (Print) First Name Middle Date of Birth

HEALTH CARE PROVIDER EXAMINATION

Please correlate the student's medical history with your findings, and record below. All entries must be completed and in English.

Male Female Height _____ Weight _____

Blood Pressure _____ / _____ Pulse _____

Current Medications: _____

Enter "N.E." if not evaluated WNL ABN Give detail of abnormality

Enter "N.E." if not evaluated	WNL	ABN	Give detail of abnormality
Head, Neck, Face and Scalp			
Nose and Sinus			
Mouth, Teeth, Gingiva and Throat			
Eyes			
Ears			
Lungs, Chest and Breast			
Heart			
Abdomen and Viscera (include hernia)			
Endocrine System			
Genito-Urinary System			
Musculoskeletal			
Skin and Lymphatic (include acne)			
Neurological System			
Psychiatric			

Is this individual capable of normal physical activity? (athletics, physical education) Yes No
 If no, give reasons and limitations/restrictions on comments line below.

- No disability Physical disability Emotional/psychiatric disability
 Learning disability History of Disordered Eating (anorexia/bulimia)

Comments: _____

I certify I have reviewed the history and immunization information and performed a physical exam on the above named patient and find him/her to be physically and emotionally healthy to the extent of participating in activities related to normal college life.

 Date of Examination

 Health Care Provider's Signature

 Print Name of Health Care Provider

 Address

 Health Care Provider Telephone

 City State Zip Code