RHODE ISLAND COLLEGE
Health Services
600 Mt. Pleasant Ave.
Providence, RI 02908
Phone: (401) 456-8055 Fax: (401) 456-8890

MEDICAL EXAMINATION – To be completed by Health Care Provider

NAME ________________________ **DATE OF BIRTH** ________________

GENERAL EXAM

	Normal	Abnormal Findings
APPEARANCE		
SKIN		
HEENT		
RESPIRATORY		
CARDIOVASCULAR		
	Arrhythmia	
	Murmur	
ABDOMEN		
SPINE		
NEUROLOGICAL		
GENITALIA (hernia)		

HEIGHT __________ **WEIGHT** __________

BP ______________ **PULSE** __________

URINALYSIS: ________ protein
________ blood
________ glucose

VISUAL ACUITY: __________ **RIGHT**
__________ **LEFT**
corrected: ____ yes ____ no

List any medications student uses:________________________________
List any life-threatening allergies:________________________________
Does this student carry an Epi-pen? **YES** **NO**

ORTHOPEDIC EXAM

MUSCULOSKELETAL EVALUATION TO INCLUDE RANGE OF MOTION, STRENGTH, FLEXIBILITY

	Normal	Abnormal Findings
NECK		
SHOULDERS		
ARMS/HANDS		
HIPS		
THIGHS		
KNEES		
ANKLES		
FEET		

CLEARANCE BASED UPON PHYSICAL EXAM AND REVIEW OF HISTORY (PLEASE ADD COMMENTS AS NEEDED TO OTHER SIDE)

________ Cleared for participation in intercollegiate athletics **OR** ________ Not cleared

Recommendations: ____
____
____

Name of Provider (print / stamp) ________________________ Phone: ________________

Signature of Provider ______________________________ Date ________________

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

FOR RIC USE ONLY: ATHLETIC CLEARANCE FORM GIVEN ____________ **SIGN** ______________________
(Date)