Bluefield College New Student Athlete Physical

Last Name First Name MI Age Sex Sport(s)

Pre-Physical (may be completed by the Bluefield College Sports Medicine Staff)

Height	Weight	%Body Fat (optional)
Blood Pressure	Pulse	O^2 Saturation
Corrected Vision	R 20/ L 20/	Glasses Contacts (circle one)
Uncorrected Vision	R 20/ L 20/	

Pupils: Anisocria? Y N Equally Reactive to Light? Y N
Mouth: Appliances? Y N Missing or Loose Teeth? Y N
Cavities in need of treatment? Y N
Skin: Any infections or lesions? Y N Rashes? Y N
Comments:

PHYSICAL (must be completed by a licensed physician, PA-C, or FNP)

EENT:
Eyes_____
Ears_____
Nose_____
Throat_____
Comments:

CHEST:
Appearance: _____
Lungs: _____
Symmetrical Breath Sounds: Y N
Wheezes: Y N

CARDIOVASCULAR: Rate:_____ Heart_____
Irregularities: Y N Murmur: Y N
Peripheral Pulses Equal: Y N Murmur w/Valsalva: Y N
Comments:

ABDOMEN: Masses: Y N Splenomegaly: Y N Hepatomegaly: Y N
Comments:

GENITOURINARY: (Males Only)
Inguinal Hernia: Y N Testicles Descended Bilaterally: Y N
Comments:

GENERAL: Do you know your sickle trait status? Y N
If yes, what is it? _____
Have you ever sustained a concussion? Y N
If yes, how many and when? _____

ORTHOPAEDIC ASSESSMENT

Have you ever had an orthopedic surgery? Y N If yes, what was it? And when?_____

Joint(s)	Left (ROM)	Right (ROM)	Comments
Shoulder			
Elbow			
Wrist			
Hand/Fingers			
Neck			
Spine			
Hip			
Knee			
Ankle/Feet			

Orthopedic Signature: _____ (optional)

Marfan's Screening

(This screening will be used to determine an athlete's predisposition to non-traumatic cardiovascular Sudden Death Syndrome.)

A positive diagnosis must have at least two to four of the following major features, positive family history, ocular, cardiovascular and musculoskeletal abnormalities.

Arm span longer than standing height?	Y	N	Comments:
Severe Kyphosis?	Y	N	Comments:
Concave Chest Deformity (pigeon chest)?	Y	N	Comments:
Positive Thumb and/or wrist sign?	Y	N	Comments:
High arched palate/hyperextensible Joints/pes planus?	Y	N	Comments:
Inguinal Hernia?	Y	N	Comments:
Nearsightedness?	Y	N	Comments:
Murmurs of aortic or mitral regurgitation and non-ejection clinics?	Y	N	Comments:
Discrepancies between femoral and brachial pulses?	Y	N	Comments:
Resting blood pressure elevated?	Y	N	Comments:
Hx. of angina, dizziness, or generalized fatigue during or after exercise?	Y	N	Comments:
Hx. of nausea or abdominal discomfort during or after exercise?	Y	N	Comments:

Disclaimer

Clearance for individuals to participate in sports is the sole responsibility of the team physician, or the physician performing this evaluation. The Marfan's screening is only a tool designed to help minimize the risk of non-traumatic cardiovascular sudden death in athletes under the age of 25.

Immunizations/Screenings (REQUIRED)

*The immunizations/screenings listed below are **required by Virginia law.***

Required immunizations/screenings:

• DPT (Diphtheria/Pertussis/Tetanus) Series

• IPV/OPV (Polio) Series

• MMR (Measles/Mumps/Rubella) Series

• Tetanus (Must have received within 10 years of registration)

Please provide/ attach a copy of your immunization record with signature of health care provider.

Immunizations/Screenings (optional, but recommended)

RECOMMENDED for All Students

Meningococcal (Meningitis) Vaccine: The risk of meningococcal disease may be increased in some subsets of college students. The American College Association recommends you receive this vaccination. In accordance with Virginia law, students who do not receive this vaccination are required to complete the enclosed waiver. Meningococcal meningitis vaccine is required by Virginia law for all new undergraduate unless a waiver is signed.

Hepatitis B Vaccine: In accordance with Virginia law, students who do not receive this vaccination are required to complete the enclosed waiver. Hepatitis B vaccine is required by Virginia law for all new undergraduates unless a waiver is signed.

Varicella (Chicken Pox) Vaccine: Based on guidelines from American College Health Association (ACHA), this immunization is recommended but not required. Consult your health care professional with questions.

Please find attached the required waiver forms.

Frequently asked questions are available at
https://www.cdc.gov/vaccines/vac-gen/common-faqs.htm

Recommendations Based on Above Evaluation

After my evaluation, I give my: (check one)

_____ Full approval for participation in athletics.

_____ Full approval for participation in athletics, but needs further evaluation by Dentist_____; Optometrist_____; Family Physician_____; Cardiologist _____; Orthopedic_____; Neurologist_____; Urologist_____; Other_____

Comments:

_____ Limited approval for participation in athletics with the following restrictions:

_____ Denial of approval for participation in athletics for the following reasons:

Physician Name (printed) Physician Signature Date

Student Affirmation (required)

My signature below indicates that the information provided on this form is accurate and complete, and that all immunizations and required screening/tests have been correctly and truthfully recorded. I also understand my signature signifies permission for release of medical information to appropriate College personnel.

_____ _____
Student Signature (full legal name) Date

_____ _____
Parent/Guardian Signature (if under 18) Date

Bluefield College Sports Medicine Staff Only

Cardiac Testing Completed :_____ Date:_____ Comments:

Physical Review Date:_____

Athletic Trainer Signature:_____

BLUEFIELD COLLEGE

Immunization Waiver Forms

Waiver of Immunization Against Hepatitis B

The Code of Virginia (Chapter 340 23-7.5) requires that "each full-time student shall be vaccinated against hepatitis B unless the student or, if the student is a minor, the student's parent or legal guardian signs a written waiver stating that he has received and reviewed detailed information on the risks associated with hepatitis B and the availability and effectiveness of any vaccine and has chosen not be or not to have the student vaccinated."

I have read the Hepatitis B Frequently Asked Questions at https://www.cdc.gov/hepatitis/hbv/bfaq.htm , and reviewed the risks associated with the disease, including the effectiveness and availability of any vaccine against Hepatitis B.

I choose not to be vaccinated against Hepatitis B.

_____ _____/_____/_____
Printed Legal Name of Student Date of Birth

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature (if under 18) Date

Waiver of Immunization Against Meningococcal (meningitis)

The Code of Virginia (Chapter 340 23-7.5) requires that "each full-time student shall be vaccinated against Meningococcal (Meningitis) unless the student or, if the student is a minor, the student's parent or legal guardian signs a written waiver stating that he has received and reviewed detailed information on the risks associated with hepatitis B and the availability and effectiveness of any vaccine and has chosen not be or not to have the student vaccinated."

I have read the Frequently Asked Questions at https://www.cdc.gov/meningococcal/about/index.html , and reviewed the risks associated with the disease, including the effectiveness and availability of any vaccine against Hepatitis B.

I choose not to be vaccinated against Meningococcal

_____ _____/_____/_____
Printed Legal Name of Student Date of Birth

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature (if under 18) Date

Consent for Medical Treatment and Release of Information for Bluefield College Student Development

As a student of Bluefield College, I realize that it is possible for a medical emergency to occur. Therefore, I hereby authorize Bluefield College Student Development permission to release the medical information listed below to the appropriate officials (i.e. Residence Life staff and Campus Safety). In the event of an emergency, I authorize treatment for myself as deemed necessary by a licensed health care professional. I understand that my records will be kept confidential at all times by these officials. I also authorize BC to release information concerning my medical condition to the following individuals:

☐ Mother ☐ Father ☐ Guardian ☐ Professors Other: _____

_____
Student Legal Printed Name

_____ _____
Student Signature Date

_____ _____
Parent/Legal Guardian Signature (required if student is not 18) Date

Please return entire packet directly to The Sports Medicine Department

By Mail:
Bluefield College
ATTN: Sports Medicine Department
3000 College Ave.
Bluefield, VA 24605

By Private Fax: 276-326-4484

Or By Email: Erika Bell, Director of Sports Medicine at ebell@bluefield.edu