



**SWARTHMORE COLLEGE**

**REQUIRED PHYSICAL EVALUATION FOR ALL INCOMING STUDENTS**

Page 1 completed by all incoming students no sooner than 12 months prior to college entrance. Page 2 completed (in addition to Page 1) by all incoming student athletes no sooner than 12 months prior to college entrance and annually thereafter. Upload completed form to your student health portal. Student athletes must upload the forms to their student health portal AND to the Sportsware portal.

Patient's Name: \_\_\_\_\_ Patient's date of birth: \_\_\_\_\_ Date of exam: \_\_\_\_\_

Height: _____ Weight: _____	Pulse: _____ BP: _____/_____	Amount of weight change in past year _____: Gain Loss
Gross hearing: R _____ L _____	Vision: Uncorrected: R _____ L _____ Corrected: R _____ L _____ Pupils: Equal _____ Unequal _____	Suspected or confirmed eating disorder: Yes No
Allergies: _____	Immunizations: ___ up to date _____ not up to date Specify: _____	Hx of COVID-19: Y or N Date: _____ Cardiologist referral: Y or N Prolonged s/s: _____

**CLINICAL EVALUATION**

MEDICAL	CIRCLE	REMARKS
Eyes/Ears/Nose/Throat	WNL	
Lymph Nodes	WNL	
Heart/Pulses	WNL	
Lungs	WNL	
Abdomen	WNL	
G.U.	WNL	
Skin	WNL	
Neuro	WNL	
Musculoskeletal	WNL	
Psychological	WNL	

Is the student able to participate in all physical activities and athletics? Yes \_\_\_\_\_ No \_\_\_\_\_ (if no, explain)

Summarize all pertinent medical and psychological conditions/treatments or suggestions for Student Health and Wellness: \_\_\_\_\_

Clinician Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**SWARTHMORE COLLEGE**  
**REQUIRED STUDENT ATHLETE PREPARTICIPATION PHYSICAL EVALUATION**

*Completed by all student athletes no sooner than 12 months prior to college entrance and annually thereafter. Upload pages 1 and 2 to your Student Health Portal AND the Sportsware portal.*

**THIS SECTION COMPLETED BY THE STUDENT ATHLETE**

Do you feel stressed out or under a lot of pressure?	YES	NO
Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	YES	NO
Do you feel safe?	YES	NO
Have you tried smoking or do you currently smoke?	YES	NO
During the past 30 days did you use chewing tobacco, snuff or dip?	YES	NO
During the past 30 days have you had at least one drink of alcohol?	YES	NO
Have you ever taken steroid pills or shots without a doctor's prescription?	YES	NO
Have you ever taken any supplements to help you gain or lose weight or improve your performance?	YES	NO
<b>I hereby authorize the Swarthmore College Student Health and Wellness Center to release any information related to my athletic participation to the Sports Medicine Department and for Swarthmore College's Sports Medicine Department to release any medical information to the Student Health and Wellness Center or to Swarthmore College's Insurance Company claims administration services.</b> Athlete signature: _____ Date: _____ Parent/Guardian (if athlete is minor): _____ Date: _____	-	-

**REQUIRED SICKLE CELL SCREENING**

As of 2022, the NCAA **requires all student athletes** to have sickle cell screening completed prior to participation in sports. Knowing sickle cell status may prevent serious complications from sports participation. **This testing only needs to be done once, prior to your first participation in athletics.**

Sickle Cell Screen Result: \_\_\_\_\_ Date of test: \_\_\_\_\_  
Clinician signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THE STUDENT ATHLETE IS:**

- Cleared without restrictions
- Cleared, with recommendation for further evaluation or treatment for:

• Not cleared for: \_\_\_ All sports \_\_\_ Certain sports: \_\_\_\_\_  
Reason: \_\_\_\_\_

Clinician Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_