PROFESSIONAL PROGRAMS

STUDENT'S HEALTH EVALUATION FORM

Exercise Physiology Program

PART 1 - To be completed by student

Name_____ Age_____ Date of Birth_____/_____/_____

Permanent Address_____

In case of emergency, notify: Name_____ Phone (_____)_____

Relationship_____ Address_____

Student's 700/800#_____

STUDENT'S MEDICAL HISTORY

Allergies	
Operations (date, type)	
Hospitalizations (date, type)	
Medical, emotional problems requiring treatment	
Medications	

STUDENT'S FAMILY HISTORY

FAMILY MEMBER	AGE(S)	STATE OF HEALTH
Mother		
Father		
Brother(s)		
Sister(s)		
Spouse		
Children		

What is your current health status?_____

Comments or additional history:_____

To my knowledge, the Medical History and Immunization information I have provided on this form is accurate and complete. I give permission to the Associate Dean and staff of Professional Programs of the WVU School of Medicine to release the necessary parts of my health forms, including records and titer results when required for on-campus clinical rotations and rotations at other institutions to which I am assigned.

Student's Signature:_____ Date:_____

Revised and effective: December 2019

PART 2 - PHYSICAL EXAMINATION *(To be completed by physician)*

Name_____ Age_____ Date of Birth_____/_____/_____

Height _____ Weight _____ Pulse _____ Respiration _____ Blood Pressure _____

Vision: OD _____/20; OS _____/20 Hearing: R _____/15; L _____/15

	NORMAL	ABNORMAL	COMMENTS
HEENT			
Neck			
Chest			
Lungs			
Heart			
Abdomen			
Genitalia			
Extremities			
Orthopedic			
Neurologic			

Summary of medical problems/concerns:

Physician Name (Please print)_____

Physician Signature_____ Date of Exam_____

Revised and effective: December 2019