



# PAUL SMITH'S COLLEGE

## CLINICAL EVALUATION

(To be no older than 1 year prior to date of entry)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_

Vision: Uncorrected    Corrected    (Glasses or Contacts)

Right: 20/\_\_\_\_\_ 20/\_\_\_\_\_

Left: 20/\_\_\_\_\_ 20/\_\_\_\_\_

Hearing:

Right: \_\_\_\_\_ ○ Aid

Left: \_\_\_\_\_ ○ Aid

General	Normal	Abnormal	Details
HEENT			
Heart			
Lungs & Chest			
Vascular System			
Abdomen			
Skin			
Upper Extremities			
Lower Extremities			
Spine & Musculoskeletal			
Neurologic			
Psychiatric			
Genitourinary			<input type="checkbox"/> Not done
Anorectal			<input type="checkbox"/> Not done

Does the student use tobacco product(s), alcohol, or illegal drugs?

If so, please specify type and quantity: \_\_\_\_\_

Does the student have a disability- physical or cognitive, which may require special arrangements?

If so, specify and send supportive documentation: \_\_\_\_\_

Please list current medications; specify condition being treated, dose/ frequency/route:

\_\_\_\_\_

\_\_\_\_\_

In your opinion, is this patient/student physically able to participate in intercollegiate athletics?

Yes  No

If not or there is a limitation, please explain \_\_\_\_\_

In your opinion, is this patient/student able to meet the physical and emotional demands of college life?

Yes  No

If not or there is a limitation, please explain: \_\_\_\_\_

Provider's Name: \_\_\_\_\_  
Print

Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_