BLACK HAWK COLLEGE ATHLETICS
MEDICAL EXAMINATION FORM

Name		**Date**			
Allergies		**DOB**		**Age**	

MEDICAL EVALUATION: To be completed by student, before physical & given to physician.

Parent or Guardian:

Address:

Phone:

PERSONAL HEALTH OF STUDENT:		
List Injuries requiring medical attention:	**List Any Surgical Operations:**	**List Any Medications Taken Regularly:**
A.	**A.**	**A**
B.	**B.**	**B**
C.	**C.**	**C.**

Do you wear contact lenses?

INSURANCE COVERAGE

1. **Are you currently covered by your parents' insurance plan?**

   Yes_____ No _____
2. **Where is/are your parent(s) employed _____**

I understand that my parent's insurance plan will provide primary coverage in case of injury.

DATE_____ STUDENT SIGNATURE _____

PHYSICAL EXAM

Height		Weight		Blood pressure		Pulse		LMP	

Head		Heart		Extremities	
Eyes		Lungs		Scrotum	
Ears		Breasts		Penis	
Nose		Abdomen		Hernia	
Throat		Vulva		Prostate	
Thyroid		Vagina		Rectal	
Nodes		Cervix			
Carotids		Uterus			
Skin		Adnexae			

Physician's explanation of abnormal findings:

_____

_____

_____

Physicians Signature_____Date_____