Please upload this signed and completed physical and complete any pending forms in your West Liberty Student Health Portal

For general questions, call 304-336-8049

PHYSICAL EXAMINATION FORM

- Physicals are required for **ALL FULL-TIME INCOMING STUDENTS** and any part time or graduate students wishing to use Student Health Services. The physical must occur no more than 12 months prior to the start of classes.
- **ALL** athletes must receive an **ANNUAL** physical. Physicals must occur no more than 6 months prior to the start of classes.
- Please **PRINT THIS FORM** and take it to your health care provider to complete.
- After your physical has been completed and signed by your provider, please **UPLOAD** it to your student health portal.

(Failure to submit a physical could exclude you from participation in athletics, certain academic programs, and receiving treatment at Student Health Services)

Student Name (please print): _____ Student ID No: _____

Major(s): _____ Sport(s): _____

The Section Below is To Be Completed by Your Health Care Provider

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Respiration: _____

Eyes Glasses: ☐ Yes ☐ No Contact Lenses: ☐ Yes ☐ No

General Health	**Normal** or **Abnormal**	Abdomen / Spleen	**Normal** or **Abnormal**
Hair, Scalp, Skin	**Normal** or **Abnormal**	Back/Spine	**Normal** or **Abnormal**
Head (Concussion History)	**Normal** or **Abnormal**	Neurological Reflexes	**Normal** or **Abnormal**
Hearing	**Normal** or **Abnormal**	Orthopedic Screening	**Normal** or **Abnormal**
Ear, Nose, Throat	**Normal** or **Abnormal**	Genitalia	**Normal** or **Abnormal**
Neck: Thyroid	**Normal** or **Abnormal**	Rectum	**Normal** or **Abnormal**
Cardiovascular Auscultation	**Normal** or **Abnormal**	Breasts	**Normal** or **Abnormal**
Lung Auscultation	**Normal** or **Abnormal**	Menstruation	**Normal** or **Abnormal**

- Recommendation of participation level in the intended **MAJOR(S)** listed above: ◯ Unlimited ◯ Limited (Explain Below):
- Recommendation of participation level in the intended **SPORT(S)** listed above: ◯ Unlimited ◯ Limited (Explain Below):

- Please note allergies or sensitivities: _____
- Please list current medications: _____
- Does the student require a special diet? _____
- Is the student presently under medical therapy or psychological counseling? _____
- Explain any physical or emotional conditions, which you consider important: _____

- Impression and Recommendations:

Health Care Provider's Signature: _____Date: _____

Print Name: _____ Phone Number: _____

Address: _____City: _____State: _____Zip: _____