

## ATHLETIC PHYSICAL EXAMINATION FORM

*The section below is to be completed by physician or staff after history and consent forms are completed.*

**Student Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **% Body Fat (optional):** \_\_\_\_\_  
**Pulse:** \_\_\_\_\_ **Blood Pressure:** \_\_\_\_\_  
**Vision:** R 20/\_\_\_\_ L 20/\_\_\_\_ **Corrected?** Yes No **Pupils equal?** Yes No

MEDICAL	Normal	Abnormal findings	Initials
Appearance			
Eyes/Ears/Throat			
Hearing			
Lymph nodes			
Heart			
Mumurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Legs/Ankles			
Feet/Toes			

Notes regarding physical exam: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Known allergies: \_\_\_\_\_

**General Wellness:**

*(Please note pertinent responses below.)*

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, or dip/snuff.
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PERMISSIONS AND CLEARANCES

In regard to athletic participation, this student is:

- Cleared without restriction  
 Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Not cleared for:       All Sports     Specified Sports: \_\_\_\_\_

Reasons/Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Examiner *(Please print or type)*: \_\_\_\_\_

*(If the Physician's Assistant or Advanced Nurse Practitioner performed the exam, please include the name and address of collaborating physician or physician's group.)*

\_\_\_\_\_

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

Signature of Examiner: \_\_\_\_\_ Date: \_\_\_\_\_