

ATHLETIC PHYSICAL FORM

Physician's Examination

Name _____ Age _____ Date of Birth ____/____/____

COMPLETE	LIMITED	Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____		
		Vision: Right 20/_____ Left 20/_____ Corrected: Y N Pupils _____		
			NORMAL	ABNORMAL FINDINGS
		Cardiopulmonary		
		Pulses		
		Heart		
		Lungs		
		Skin		
		Abdominal		
		Musculoskeletal		
		Neck		
		Shoulder		
		Elbow		
		Wrist		
Hand				
Back				
Knee				
Ankle				
Foot				
Other				

CLEARANCE

A. CLEARED

B. CLEARANCE DEFERRED until completing evaluation/rehabilitation for:

C. NOT Cleared for: Collision
 Contact
 Non-contact
 Strenuous Moderately Strenuous Non-strenuous

Due to: _____

Recommendation: _____

Examining Physicians (Must be MD, DO, PA, or Nurse Practitioner) **MUST HAVE STAMP** and Date

Medical Personnel Signatruue and Stamp _____ Date _____