Preparticipation Physical Evaluation

(To be completed at time of physical)

PHYSICAL EXAMINATION

Name: ____Date of Birth:_____________

Height: ___________Weight:___________% Body fat (optional):______Pulse:_____________

BP: (__ ____/______) (_____/______) (_____/______)

Vision R 20/_____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	*Initials
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/high			
Knee			
Leg/ankle			
Foot			

*Station based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: ________________________________

____

____

____

____

☐ Not cleared for: ___________________________Reason:______________________________

Recommndations: ____

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Name of physician (print/type) _____________________________Date: ___________________

Address: ____Phone:___________________

Signature of physician: ____M.D. or D.O.

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