PHYSICAL EXAMINATION FORM

First Name | Middle Name | Last Name | Date of Birth

Gender ☐ M ☐ F | Age | Grade

PHYSICAL EXAM - To Be Completed By Physician or trained medical personnel under the supervision of a physician.

Height | Weight | Pulse | Blood Pressure

Medical	Normal	Abnormal Findings	Initials
1. Eyes (vision)			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck/Lymph Nodes			
5. Cardiovascular			
6. Abdomen			
7. Chest & Lungs			
8. Skin			
9. Genetalia - Hernia (male)			
10. Heart			

Musculoskeletal: ROM,Strength,etc	Normal	Abnormal Findings	Initials
Neck			
Spine/Back			
Shoulders/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thighs			
Knees			
Leg/Ankles			

_____ Cleared without restriction
_____ Cleared, with recommendations for further evaluation or treatment for:_____
_____

_____ Not Cleared: _____ All Sport _____ Certain Sports:_____

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sport. I also certify that I am a licensed physician or work directly with a licensed physician.

Physician's Signature:_____ Date:_____

Physician's Address:_____