

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: _____

Recommendations: _____

Name of physician (print/type) _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____ M.D. or D.O.