Physical Form

Name: _____ Date of Birth: _____ Sport: _____

Height: _____ Weight: _____ BP: ____/____ Pulse: _____

Vision: R ____/____ L ____/_____ Contacts (Y/N) Glasses (Y/N)

	Normal	Abnormal	Comments
HEART			
Rhythm			
murmur			
ENT			
Lungs			
Skin			
Abdominal			
Genitalia			
Musculoskeletal			
Neck			
Shoulders			
Elbows			
Wrists/Hands			
Back			
Knees			
Ankles			
Hips			
Feet			
Dental			
Sickle Cell			
Other			

After having reviewed the data above and the student's medical history, I make the following recommendations on participation in athletics:

1. Cleared _____
2. Cleared after additional evaluation for _____
3. Restricted from participating in the sports of _____
4. Cleared only to participate in the sports of _____

I have examined the physical condition of the student and find the said student to be physically fit to practice for and participate in intercollegiate athletic contests.

_____ _____

Physician Signature Date

Provider's Name (Please Print)	
Address:	
City/State/Zip	
Phone number	