

SPORTS & ATHLETIC – PHYSICAL EXAMINATION
(to be completed and signed by examining physician)

NAME: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____ GRADE: _____

*Tanner Stage or Maturation Index _____ BP _____

*Percent Body Fat _____ Pulse(rest) _____ (Exercise) _____ (Recovery) _____

*Vision: Corrected (L) _____ (R) _____ Both _____

Uncorrected (L) _____ (R) _____ Both _____

*Audiogram: _____ Cervical spine/neck _____

Back _____

Eyes _____ Shoulders _____

Ears _____ Arm/elbow/wrist/hand _____

Nose _____ Knees/hips _____

Throat _____ Ankles/feet _____

Skin _____

LAB:
*Urine _____
*Hemoglobin or HCT _____
and or Fe Stores _____

Lymphatic _____

Lungs _____

Heart _____

Abdomen _____

Genitalia/hernia _____

Peripheral pulses _____

***WHEN MEDICALLY INDICATED**

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

_____ Full Participation _____ Limited Participation

_____ No Participation _____ Needs Additional Evaluation

If not full participation, give reasons and recommendations: _____

Any recommendations or concerns on such items as:

a. Weight loss or gain or restrictions of weight loss: _____

Slow and careful monitoring of conditioning because of being overweight or show an abnormal exercise testing: _____

c. Other: _____

Physician Signature: _____, M.D.* Date: _____

*Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner

Physician Name(PRINT) _____

Address: _____ City/Zip Code: _____

Telephone Number: _____