ATHLETIC PHYSICAL FORM

Physician's Examination

Name _____ Age _____ Date of Birth _____/_____/_____

COMPLETE / LIMITED

Height _____ Weight _____ Blood Pressure _____/_____ Pulse _____

Vision: Right 20/_____ Left 20/_____ Corrected: Y N Pupils _____

	NORMAL	ABNORMAL FINDINGS
Cardiopulmonary		
Pulses		
Heart		
Lungs		
Skin		
Abdominal		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

CLEARANCE

A. CLEARED

B. CLEARANCE DEFERRED until completing evaluation/rehabilitation for:

_____

C. NOT Cleared for: ☐ Collision
☐ Contact
☐ Non-contact
☐ Strenuous ☐ Moderately Strenuous ☐ Non-strenuous

Due to: _____

Recommendation: _____

_____

Examining Physicians (Must be MD, DO, PA, or Nurse Practitioner) MUST HAVE STAMP and Date

Medical Personnel Signature and Stamp _____ Date _____