PHYSICAL EXAMINATION FORM

Name_______________________________________ Date of Exam_________________ Sport/s____________________________

Date of Birth_______________ Age__________ Grade ___________ Sex_________ Height_____________ Weight_____________

Vision R 20/_______ Vision L 20/_______ Corrected: ☐ Y ☐ N BP_______ / _______ Pulse ________

To Filled Out By Your Doctor Only	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL EVALUATION			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			
Lymph Nodes			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

Notes: ____

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☐ Cleared for all sports without restriction ☐ Cleared for certain sports only _________________

☐ Not cleared for any sports. Reason:____

Medical Clinic Stamp

Name of physician (print/type)_________________________________Date_______________

Address____Phone________________

Signature of physician____, MD,DO,NP,PA