

PRE-PARTICIPATION PHYSICAL EXAM (Athletes Only. To be completed by Physician)

Name _____ Age _____ Date _____

Height _____ Weight _____ Blood Pressure _____ / _____ Heart Rate _____

Vision: Right 20/____ Left 20/____ Corrected? Yes No Contacts Glasses

MEDICAL	NORMAL	ABNORMAL FINDINGS
Eyes/Ears/Nose/Throat		
Mouth and Teeth		
Lymph Nodes		
Heart		
Pulse		
Lungs		
Abdomen		
Skin		
Genitalia- Hernia (male)		
Musculoskeletal		
Neck		
Spine		
Shoulders		
Arms/Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		
Neuromuscular		
Sickle Cell Trait Test		

Further Medical Evaluation Required: _____

Cleared to Participate Not cleared to participate Date _____ Phone _____

Print Name _____ Signature _____

(MD, DO, or PA only)