



### PROVIDER'S PHYSICAL EXAMINATION FORM

Athlete Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

EXAMINATION: TO BE FILLED OUT BY MEDICAL PROVIDER ONLY		
Height: _____ Weight: _____		
Pulse: _____ BP: _____ / _____ Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N Pupils: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal		
MEDICAL (Please initial)	NORMAL	ABNORMAL FINDINGS
Appearance (Marfan stigmata)		
Eyes/Ears/Nose/Throat (pupils equal, hearing)		
Lymph Nodes		
Heart (murmurs)		
Pulses (simultaneous femoral and radial)		
Lungs		
Abdomen		
Skin (HSV, MRSA, tinea corporis)		
Neurological		
Genitourinary (males only)		
MUSCULOSKELETAL (Please initial)	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hands/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional (double-leg squat test, single-leg squat test, box drop or step drop test)		

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CLEARANCE

Cleared without restriction  
 Cleared with recommendations for further evaluation or treatment for: \_\_\_\_\_

\_\_\_\_\_  
 Not cleared for  All sports  Certain sports \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Physician/Medical Provider [print or type]: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician/Medical Provider: \_\_\_\_\_