

PHYSICAL EXAM

NAME_____

DATE_____

BIRTH DATE_____

STUDENT ID #_____

BLOOD PRESSURE	PULSE	HEIGHT	WEIGHT
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VISION: R 20/____ L 20/____ CORRECTED: Y N PUPILS: EQUAL____ UNEQUAL____

GENERAL ASSESSMENT

AREA	NORMAL	ABNORMAL	COMMENTS
HEAD			
EYES			
ENT			
LUNGS			
CARDIOVASCULAR			
ABDOMEN			
GU			
SKIN			
NEUROLOGICAL			
CLEARED TO PARTICIPATE IN SPORT		<input type="radio"/>	PENDING CONSULTATION <input type="radio"/>
CLINICIAN'S NAME		CREDENTIAL	
CLINICIAN'S SIGNATURE		ADDITIONAL NOTES	
PHONE	DATE		

REVIEWED BY:

DATE: