

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		