



PHYSICAL EXAMINATION (To be completed by a Physician. Physical must be dated 6/1/16 or later.)

Athlete's Name: _____ Sport: _____

Date of Birth: _____

Height: _____ Weight: _____

Pulse: _____ Blood Pressure _____ / _____

Clinical Evaluation:

Normal	Abnormal	Check each item in appropriate column.
		1. HE ENT
		2. LUNGS and CHEST
		3. HEART
		4. ABDOMEN/hernia
		5. G-I SYSTEM
		6. MUSCULOSKELETAL
		7. SKIN, LYMPHATIC GLANDS
		8. NEUROLOGIC
		9. PSYCHIATRIC (specify any known treatment of mental illness/depression, personality disorders, etc.)

Notes: Describe any abnormality:

Is this student able to compete in varsity athletics for the 2017-2018 academic year? ___Yes ___ No

If NO, please explain below:

Recommendations/ Restrictions (lifting, sports, etc)

Signature of Physician

Address

Please Print Physicians Name

City/State/Zip

Date of physical exam

Telephone Number

