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: ☐ Y ☐ N Pupils: ☐ Equal ☐ 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: _____

(Updated 4/24)