Rev. May 2024

PHYSICAL EXAM

CONFIDENTIAL DOCUMENT

First Name: _____ Middle Initial: ____ Last Name: _____

Sport (1): _____ Height: ___ ft. ___ inches Gender: _____ Date of Birth: _____ Age: _____

Sport (2): _____ Weight: _____ lbs. Body Temp: _____ F

Vision Corrected? ☐ Yes ☐ No ☐ Glasses ☐ Contacts

Date of Vitals: _____ Pulse: _____ bpm

Vitals Taken By: _____ BP: ____ / ____ mm Hg

Vision (L): 20/____ Vision (R): 20/____ ← Required

MEDICAL	EXAMINATION FINDINGS		NOTES ON ABNORMAL FINDINGS	INITIALS
Appearance	☐ Normal	☐ Abnormal		
Eyes / Ears / Nose / Throat	☐ Normal	☐ Abnormal		
Hearing	☐ Normal	☐ Abnormal		
Lymph Nodes	☐ Normal	☐ Abnormal		
Heart	☐ Normal	☐ Abnormal		
Pulses	☐ Normal	☐ Abnormal		
Lungs	☐ Normal	☐ Abnormal		
Abdomen	☐ Normal	☐ Abnormal		
Skin	☐ Normal	☐ Abnormal		
MUSCULOSKELETAL				
Neck	☐ Normal	☐ Abnormal		
Back	☐ Normal	☐ Abnormal		
Shoulder / Arm	☐ Normal	☐ Abnormal		
Elbow / Forearm	☐ Normal	☐ Abnormal		
Wrist / Hand / Fingers	☐ Normal	☐ Abnormal		
Hip/Thigh	☐ Normal	☐ Abnormal		
Knee	☐ Normal	☐ Abnormal		
Leg / Ankle	☐ Normal	☐ Abnormal		
Foot / Toes	☐ Normal	☐ Abnormal		

Date of Physical Exam: _____

I have examined the above-named patient. I have either conducted or reviewed the student-athletes pre-participation physical evaluation, and the athlete is cleared for participation in intercollegiate athletics as outlined below. If conditions arise after the student-athlete has been cleared for participation, the physician or athletic trainer may rescind clearance.

- ☐ Cleared for all sports without restrictions
- ☐ Cleared for all sports with recommendations for further evaluation or treatment.
- ☐ Not cleared:
  - Pending further evaluation
  - For any sports
  - For certain sports only: _____

Comments / Recommendations: _____

_____

Signature of Examining Physician: _____

Printed Name of Examining Physician: _____

Physician's Address: _____

Physician's Phone: _____

SICKLE CELL TRAIT REQUIREMENT:

NCAA Requires institutions to know the sickle cell trait status for all student-athletes. More info at gculions.com/SCT. If your patient is a new to Georgian Court, please attach copies of labratory report(s) from neonatal testing or order one of the following labratory test, and **attach results**.

Sickle cell screen with reflex to hemoglobinopathy fraction cascade

Quest Diagnostics: Quest test #37679, CPT 85660

Labcorp: Labcorp test #005330. CPT 85660

If preliminary screening is positive, confirmation testing to differentiate Sickle Cell Disease vs. Trait is required.

As per NCAA requirements, this form will only be accepted if signed by a physician (M.D. or D.O.)

We Can NOT accept signature from PA, NP, APN, etc.