



## ATHLETE PHYSICAL FORM

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
                     LAST                    FIRST                    MIDDLE

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BP \_\_\_\_\_ PULSE \_\_\_\_\_  
 VISION: Left \_\_\_\_\_ Right \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

**To be completed by Team Physician**

	NORMAL	ABNORMAL	EXPLAIN
1. GENERAL APPEARANCE			
2. SKIN (rashes, lesions, etc)			
3. HEAD (hair, scalp, face)			
4. EYES (pupils, EOM's)			
5. EARS/NOSE			
7. MOUTH/THROAT (including hygiene)			
8. CHEST/LUNGS			
9. HEART (size, rhythm, sound)			
10. ABDOMEN (masses, tenderness, BS)			
11. MALE GENITALIA			
12. EXTREMITIES/SPINE			
13. NEUROLOGIC			

14. PSYCHIATRIC (any known psychiatric deviations)

**15. LAB WORK/ADDITIONAL TESTS NEEDED:**

TESTED FOR SICKLE CELL TRAIT (CIRCLE ONE): YES/NO INITIALS OF ADMINISTRATOR: \_\_\_\_\_

RESULTS (CIRCLE ONE): POSITIVE/NEGATIVE

**COMMENTS:**

CLEARED FOR PARTICIPATION (circle one) YES NO (EXPLAIN)

**FOLLOW-UP NEEDED:** YES NO

\_\_\_\_\_  
 Physician Signature

\_\_\_\_\_  
 Date