Pre-Participation Physical Evaluation

(To be completed at time of physical)

PHYSICAL EXAMINATION

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ % Body fat (optional):_____ Pulse: _____
BP: (_____/_____) (_____/_____) (_____/_____)
Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal Unequal

	Normal	Abnormal Findings	*Initials
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station based examination only

CLEARANCE

□ Cleared
□ Cleared after completing evaluation/rehabilitation for: _____
_____
_____
_____

□ Not cleared for: _____ Reason: _____
Recommendations: _____
_____
_____
_____

Name of physician (print/type) _____ Date: _____
Address: _____ Phone: _____
Signature of physician: _____ M.D. or D.O.