



# PHYSICAL EXAMINATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## To be completed by athlete/parent prior to physical:

HISTORY	YES	NO	HISTORY	YES	NO	HISTORY	YES	NO
Have you ever had:			Have you ever had:			Do you now have:		
Fainting			Kidney Disease			Painful Joints		
Diphtheria			Tuberculosis			Backaches		
Scarlet Fever			Jaundice			Pounding of Heart		
Rheumatism			Sickle-Cell Anemia			Shortness of Breath		
Rupture						Frequent Urination		
Rheumatic Fever						Cough		
			Do you now have:					
Poliomyelitis			Blurred Vision			Nosebleeds		
Pneumonia			Headaches			Frequent Sore Throats		
Asthma			Fainting			Stomach Pains		
Diabetes			Convulsions					
Heart Disease			Blackouts					
Heart Murmur								
Chest Pain								

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## To be completed by examining MD, DO, Physician's Assistant on day of physical:

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

### PHYSICAL EXAMINATION

To be completed by the examining MD, DO, Physician's Assistant or Nurse Practitioner.  
(Categories may be added or deleted; check appropriate column.)

SYSTEM	NORMAL	ABN.	SYSTEM	NORMAL	ABN.
Urinalysis			Chest		
Vision			Lungs		
Ears			Heart		
Nose			Abdomen		
Throat			Hernia		
Teeth-Cavities			Genitalia/Testicular Exam		
Orthopedic			Neurologic		
Thyroid			Muscular		

RECOMMENDATIONS: \_\_\_\_\_

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities not crossed out below.

BASEBALL—BASKETBALL—BOWLING—COMPETITIVE CHEER—CROSS COUNTRY—FOOTBALL—GOLF—GYMNASTICS—SOCCER—  
SOFTBALL—SWIMMING—TRACK—TENNIS—VOLLEYBALL—WRESTLING

**A CURRENT YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR.**

SIGNATURE OF EXAMINER: X \_\_\_\_\_

CIRCLE ONE: MD DO PA NP \_\_\_\_\_

PRINTED NAME OF EXAMINER: \_\_\_\_\_

DATE: \_\_\_\_\_