



PHYSICAL EXAMINATION

Students participating in varsity athletics MUST be examined within six months of beginning sports.
All other students should be examined within one year of beginning classes.

Last Name: _____ First Name: _____ DOB: _____

System	Normal	Abnormal	Explanation of Abnormal Findings
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose, throat, teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck, thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest, breasts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen, liver, spleen, kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pelvic (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities, back, spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	_____

Ht _____ Wt. _____ BP _____ T _____ P _____ R _____

ALLERGIES (please list ALL allergies to medications, foods and other miscellaneous items)

Medications: _____

Food: _____

Other (bees, latex, nuts, seasonal/pollen) _____

MEDICATIONS (include prescriptions, over-the-counter, and herbal)

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Is this patient medically cleared to participate in intramural or intercollegiate athletics programs, including contact or collision sports?

YES NO

Provider Signature: _____ Date of Examination: _____

Provider Name: _____ Phone: _____ Fax: _____

Address: _____