



2019-20 PHYSICAL EXAMINATION (TO BE COMPLETED BY PHYSICIAN)

Name of Athlete Examined _____

Height _____ Weight _____ Pulse _____ bpm Blood Pressure: sys _____ dia _____
Visual Acuity (R) 20/ _____ (L) 20/ _____

CLINICAL EXAM: Check each item in appropriate column. Elaborate as needed.

Examination	Nor	Abn	Description
H.E.E.N.T			
PUPIL SIZE			
SKIN			
HEART			
LUNGS			
ABDOMEN			
HERNIA (MALES)			
NEUROLOGICAL			
SPINAL COLUMN			
UPPER EXTREMITIES			
LOWER EXTREMITIES			

Comments and Recommendations:

Restrictions:

Physician Name _____

Physician Signature _____

Date _____

I agree that the information on this physical examination sheet is accurate to my knowledge and have asked questions regarding my health and understand and will follow recommendations and restrictions as described above

Student-Athlete Signature _____

Date _____