ATHLETICS PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

SAM HOUSOTN STATE UNIVERSITY SPORTS MEDICINE

Name _____ Student ID#_____ Sport _____

Pulse Rate _____ Temp. _____ Height _____ Weight _____ BP _____

Vision Corrected Y N R20/_____ L20/_____ Pupils: Equal _____ Unequal_____

Physical Exam (Please elaborate on **any** abnormality reported in the history)

MEDICAL	N	ABN	ABNORMAL FINDINGS
Head, Face, & Scalp			
Mouth, Nose & Throat			
Eyes			
Ears			
Neck (thyroid)			
Lungs and Chest			
Heart (RRR without murmur)			
Vascular System			
Abdomen			
Genitalia (Male Only)			
Skin			
Neurologic			

Orthopedic Screen	N	ABN	ABNORMAL FINDINGS
Neck			
Shoulder			
Elbows			
Hands/Wrist			
Spine/Pelvis/Hips			
Knees			
Ankles			
Feet			

Recommendations/Preventive measure: _____

_____

Clearance: (Check appropriate category):

☐ No Limitations Recommended
☐ Recommendations to be address prior to participation in Athletics:_____
☐ Recommendations NOT limiting participation in Athletics:_____

Physician's Name: _____ MD or DO (please circle one)

Physician's Signature: _____ Date: _____