



DOCTOR PHYSICAL EXAMINATION

Full Name: _____ Date of Birth: _____

Organization: Moreau Catholic High School

Height: _____ BP: _____ Vision Right: 20 / _____ Hearing Right: _____

Weight: _____ Pulse: _____ Vision Left: 20 / _____ Hearing Left: _____

Skin Color: _____ BMI%: _____ Contacts: Yes No

Cervical NL AB Flex/Ext
 NL AB Rotation right/left
 NL AB Lateral flexion right/left

Shoulder NL AB Forward flexion/ext
 NL AB Abduction/Adduction
 NL AB Internal/Ext rotation
 NL AB Horizontal Abd/Add
 NL AB A-C Joint/Clavicle
 NL AB Stability Testing
 NL AB Biceps flex/ext
 NL AB Elbow supination/pronation
 NL AB Wrist/Hand

Knee NL AB Patellar tendon
 NL AB Tibial tuberosity
 NL AB MCL/LCL
 NL AB ACL/PCL
 NL AB Cartilage testing
 NL AB Quads/Hamstrings
 NL AB Gastroc/Soleus complex
 NL AB Patella crepitus
 NL AB Patella tracking

Hip NL AB Hip flexors/gluteals
 NL AB Add/Abd-groin/IT Band
 NL AB Int/Ext rotation

Ankle NL AB Plantar/Dorsiflexion
 NL AB Inversion/Eversion
 NL AB Subtalar joint
 NL AB Ligament Testing
 NL AB Feet/Toes

**Thoracic/
Lumbar** NL AB Flex/Ext
 NL AB Rotation right/left
 NL AB Lateral flexion right/left
 NL AB Abdominals/Obliques

**General
Flexibility** NL AB Hamstrings
 NL AB Quadriceps
 NL AB Lumbar Spine
 NL AB Achilles

Other NL AB Eyes, Ears, Nose, Throat
 NL AB Lungs
 NL AB Heart
 NL AB Abdomen
 NL AB Genitalia/Hernia

Describe Abnormals: _____

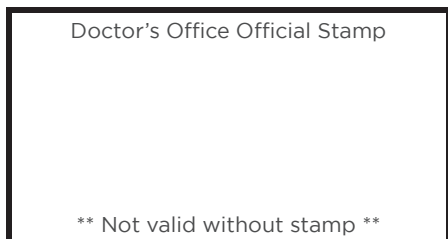
Cleared for all sports - No Restrictions

Not cleared for any sports

Not cleared for certain sports

Not cleared pending further evaluation

Recommendation: _____



Date of physical: _____ **(Not accepted without)**

Name of Physician: _____

Address: _____

Phone: _____

Signature of Physician: _____