PHYSICAL EXAMINATION

Age:_____ Pulse:_____

Height:_____ Blood Pressure:_____

Weight:_____ Visual Acuity: Left 20/_____
Right 20/ _____

Optional

Urinalysis:

Body Fat %

HCT:

EST VO2 Max:

Audiometry:

Normal			Abnormal	
☐	1.	Head	☐	_____
☐	2.	Eyes (pupils), ENT	☐	_____
☐	3.	Teeth	☐	_____
☐	4.	Chest	☐	_____
☐	5.	Lungs	☐	_____
☐	6.	Heart	☐	_____
☐	7.	Abdomen	☐	_____
☐	8.	Genitalia	☐	_____
☐	9.	Neurologic	☐	_____
☐	10.	Skin	☐	_____
☐	11.	Physical Maturity	☐	_____
☐	12.	Spine, Back	☐	_____
☐	13.	Shoulders, Upper extremities	☐	_____
☐	14.	Lower extremities	☐	_____

Assessment: ☐ Full participation

☐ Limited participation (describe limitations, restrictions):

_____

_____

☐ Participation contraindicated (list reasons):

_____

_____

Recommendations (equipment, taping, rehabilitation, etc.):

_____

_____

DATE: _____ EXAMINER'S SIGNATURE: _____

EXAMINER'S PHONE: ( )_____ PRINT EXAMINER'S NAME: _____

Please Note: Physical is valid for 24 months from the date of signature unless otherwise indicated above.