



**2007-08 PHYSICAL EXAMINATION  
TO BE COMPLETED BY PHYSICIAN**

Name of Athlete Examined \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure (1) \_\_\_\_\_ (2) \_\_\_\_\_ Visual Acuity (R) 20/ \_\_\_\_\_ (L) 20/ \_\_\_\_\_

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

Nor	Abn	
		H.E.E.N.T _____
		Pupil Size _____
		Skin _____
		Heart _____
		Lungs _____
		Abdomen _____
		Hernia and Genitalia (males) _____
		Neurological _____
		Spinal Column (scoliosis, etc.) _____
		Upper Extremities _____
		Lower Extremities _____

COMMENTS AND RECOMMENDATIONS:

\_\_\_\_\_  
\_\_\_\_\_

RESTRICTIONS:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician (PLEASE PRINT)

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Phone Number

I agree that the information on this 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