

PHYSICAL EXAMINEE NAME _____

AGE _____ DATE _____

GENERAL APPEARANCE:

VISUAL TEST: WITH GLASSES OD _____ OS _____
WITHOUT GLASSES OD _____ OS _____
COLOR VISION-NORMAL _____ ABNORMAL _____

SKIN:

LYMPH NODES:

EYES:

EARS:

NOSE:

MOUTH AND THROAT:

NECK:

THORAX AND LUNGS:

HEART:

BREASTS:

ABDOMEN:

EXTREMITIES:

WEIGHT _____

HEIGHT _____

URINE _____

B/P _____

PULSE _____

ALLERGIES _____

FUNDI:

HEARING:

THYROID:

HERNIA:

BACK:

CNS:

ADDITIONAL COMMENTS:

SUMMARY

1. APPROVED ALL SPORTS
2. NOT
3. APPROVED WITH THE FOLLOWING RESTRICTIONS _____

DATE: _____ ATTENDING PHYSICIAN: _____