

# Physical Examination

Optional

Name: \_\_\_\_\_  
 Age: \_\_\_\_\_ Pulse: \_\_\_\_\_  
 Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_  
 Weight: \_\_\_\_\_ Visual Acuity: Left 20/\_\_\_\_\_  
 Right 20/\_\_\_\_\_

Urinalysis: \_\_\_\_\_  
 Body Fat %: \_\_\_\_\_  
 HCT: \_\_\_\_\_  
 EST VO2 Max: \_\_\_\_\_  
 Audiometry: \_\_\_\_\_

Normal	Abnormal	Examiner's Comments
<input type="checkbox"/> 1. Head	<input type="checkbox"/>	_____
<input type="checkbox"/> 2. Eyes (pupils), ENT	<input type="checkbox"/>	_____
<input type="checkbox"/> 3. Teeth	<input type="checkbox"/>	_____
<input type="checkbox"/> 4. Chest	<input type="checkbox"/>	_____
<input type="checkbox"/> 5. Lungs	<input type="checkbox"/>	_____
<input type="checkbox"/> 6. Heart	<input type="checkbox"/>	_____
<input type="checkbox"/> 7. Abdomen	<input type="checkbox"/>	_____
<input type="checkbox"/> 8. Genitalia	<input type="checkbox"/>	_____
<input type="checkbox"/> 9. Neurologic	<input type="checkbox"/>	_____
<input type="checkbox"/> 10. Skin	<input type="checkbox"/>	_____
<input type="checkbox"/> 11. Physical Maturity	<input type="checkbox"/>	_____
<input type="checkbox"/> 12. Spine, Back	<input type="checkbox"/>	_____
<input type="checkbox"/> 13. Upper extremities	<input type="checkbox"/>	_____
<input type="checkbox"/> 14. Lower extremities	<input type="checkbox"/>	_____

Assessment:  Full participation  
 Limited participation (describe limitations, restrictions):  
 \_\_\_\_\_  
 \_\_\_\_\_

Participation contraindicated/not recommended (list reasons):  
 \_\_\_\_\_  
 \_\_\_\_\_

### Examiner's Certification

Date of complete physical examination: \_\_\_\_\_

I hereby certify that the above named individual's physical condition is adequate to participate in supervised activities not crossed out below:

Cross Country   
  Football   
  Volleyball   
  Basketball   
  Track   
  Cheerleading

\_\_\_\_\_ Date

Examiner's Signature