

PREPARTICIPATION PHYSICAL EXAMINATION

Student Athlete Name _____ Date of Birth (month/day/year) _____ Sport _____

 Male Female

Height ^{inches} _____ Weight ^{lbs.} _____ Body Composition (optional) ^{% body fat} _____ Pulse ^{bpm} _____ Blood Pressure _____

The pre-participation physical examination (PPE) must be performed by a licensed physician (M.D. or D.O) or an authorized physician assistant or family nurse practitioner.

Physical Examination

Medical	WNL	Abnormal Findings	Medical	WNL	Abnormal Findings
Skin	<input type="checkbox"/>	_____	Chest		
Mouth/Teeth	<input type="checkbox"/>	_____	Pulses	<input type="checkbox"/>	_____
Eyes/Ears	<input type="checkbox"/>	_____	Rhythm	<input type="checkbox"/>	_____
Nose/Throat	<input type="checkbox"/>	_____	Lungs	<input type="checkbox"/>	_____
Lymphatic			Abdomen	<input type="checkbox"/>	_____
Cervical	<input type="checkbox"/>	_____	Hernia	<input type="checkbox"/>	_____
Axillary	<input type="checkbox"/>	_____			
Orthopedic	WNL	Abnormal Findings	Orthopedic	WNL	Abnormal Findings
Foot/Toes	<input type="checkbox"/>	_____	Hand/Fingers	<input type="checkbox"/>	_____
Ankle	<input type="checkbox"/>	_____	Wrist	<input type="checkbox"/>	_____
Knee	<input type="checkbox"/>	_____	Elbow	<input type="checkbox"/>	_____
Hip	<input type="checkbox"/>	_____	Shoulder	<input type="checkbox"/>	_____
Back/Spine	<input type="checkbox"/>	_____	Head/Neck	<input type="checkbox"/>	_____

ATHLETE PARTICIPATION STATUS

- Full Participation
- Limited Participation
- No Participation

Recommendations:

- Cardiac Testing
- Rehabilitation
- Isokinetic Testing
- Other Specify _____

Comments/Restrictions/Recommendations

Physicians Signature _____

Date of Physical Examination _____

Physician Name (Print) _____

Phone Number _____

Fax Number _____

Physician Address _____

City _____

State _____ Zip Code _____