PHYSICAL EXAMINATION FORM

*****DUE PRIOR TO STARTING ANY PRACTICE*****

Note to Physician: Your careful examination and written recommendation will encourage personal fitness and safe participation in strenuous sports activities. Please complete the following physical evaluation and review medical history with participant.

PARTICIPANT'S NAME: _____

AGE: _____ **WEIGHT:** _____ **Blood Pressure:** _____ **Pulse:** _____

	Normal	**Abnormal**
Eyes/Ears/Nose/Throat	_____	_____
Heart	_____	_____
Lungs	_____	_____
Abdomen	_____	_____
Hernia	_____	_____
Extremities	_____	_____
Spine (Posture)	_____	_____

Medical history: Check any of the following illnesses or symptoms that have occurred to the participant in the past or present time.

____ Asthma ____ Fainting ____ Diabetes ____ Headaches

____ Heart Trouble ____ Seizure Disorder ____ Other: _____

Allergies: _____

Medical Allergies: _____

____ Cleared for sports without restrictions

____ Not cleared: _____

_____ _____

Examiner's Signature/Title *(Physician, NP, RN, Intern)* **Date**