



**Athletic Department Preparticipation Examination Form**

Student: \_\_\_\_\_

TO BE COMPLETED BY EXAMINING PHYSICIAN

Height: \_\_\_\_\_

Vision: \_\_\_\_\_/20 Right

Corrected? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ /20 Left

Weight: \_\_\_\_\_

Pulse: \_\_\_\_\_/minute

Blood Pressure: \_\_\_\_\_/\_\_\_\_\_

Hearing: Right \_\_\_\_\_ Left \_\_\_\_\_

	Normal	Abnormal Findings/Follow-up	Initials
HEENT			
Heart			
Lungs			
Abdomen			
Skin			
Hernia			
Other			
Neuro-Musculoskeletal			
Neck			
Scoliosis			
Arms			
Legs			
Reflexes			
Other			

**RECOMMENDATIONS:**

OK for all sports \_\_\_\_\_

Requires follow-up: As above \_\_\_\_\_

Before clearance \_\_\_\_\_

Restricted to: Limited contact/impact \_\_\_\_\_

Non-contact strenuous \_\_\_\_\_

Moderately strenuous \_\_\_\_\_

Non-strenuous \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_