

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 % Body Fat (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_  
 BP: \_\_\_\_ / \_\_\_\_ ( \_\_\_\_ / \_\_\_\_, \_\_\_\_ / \_\_\_\_ )  
 Vision: R20/\_\_\_\_ L20/\_\_\_\_ Corrected: Y  N   
 Pupils: Equal  Unequal

	Normal	Abnormal Findings	Initials *
<b>Medical</b>			
Appearance	<input type="checkbox"/>		
Eyes/Ears/Throat/Nose	<input type="checkbox"/>		
Hearing	<input type="checkbox"/>		
Lymph Nodes	<input type="checkbox"/>		
Heart	<input type="checkbox"/>		
Murmurs	<input type="checkbox"/>		
Pulses	<input type="checkbox"/>		
Lungs	<input type="checkbox"/>		
Abdomen	<input type="checkbox"/>		
Genitourinary &	<input type="checkbox"/>		
Skin	<input type="checkbox"/>		
<b>Musculoskeletal</b>			
Neck	<input type="checkbox"/>		
Back	<input type="checkbox"/>		
Shoulder/Arm	<input type="checkbox"/>		
Elbow/Forearm	<input type="checkbox"/>		
Wrist/Hands/Fingers	<input type="checkbox"/>		
Hip/Thigh	<input type="checkbox"/>		
Knee	<input type="checkbox"/>		
Leg/Ankle	<input type="checkbox"/>		
Foot/Toes	<input type="checkbox"/>		

\* - Multi-examiner set-up only | & - Having a third party present is recommended for the genitourinary examination

NOTES:

Cleared Without Restriction   
 Cleared With Following Restriction: \_\_\_\_\_  
 Not Cleared For:  All Sports  Certain Sports: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of:

Recommendations: \_\_\_\_\_

Name of Physician (Print/Type): \_\_\_\_\_ Exam Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Signature of Physician: \_\_\_\_\_, MD/DO/ND/NMD/NP/PA-C/CCSP