

# NORTH CENTRAL UNIVERSITY ATHLETICS PHYSICAL EXAMINATION FORM

(Please type or print)

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Last First Middle  
Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_ BP \_\_\_\_/\_\_\_\_

Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

Normal

Abnormal Findings

Initials\*

## MEDICAL

	Normal	Abnormal Findings	Initials*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

## MUSCULOSKELETAL

	Normal	Abnormal Findings	Initials*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

## CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- \_\_\_\_\_
- Not Cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_
- Recommendations: \_\_\_\_\_
- \_\_\_\_\_

I certify that I have on this date examined this student and that, on the basis of examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities.

\_\_\_\_\_  
Physician's Name & Address (stamp or print)

\_\_\_\_\_  
Examiner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner performed the exam, name & address of collaborating physician or physician group

\_\_\_\_\_  
Examiner's Telephone Number

