PHYSICAL EXAMINATION FOR SPORTS PARTICIPATION

To be completed by Licensed Medical Provider

To the Medical Provider: Please obtain and review the student's health history, pages one through four of this form, before conducting the examination. The intent of this exam is to focus on conditions of the athlete that may endanger his/her health, aggravate pre-existing conditions or increase the risk of death from participation in competitive college sports. If your findings or observations during this exam for sports participation indicate a need for a more comprehensive medical examination, you have the option of conducting a more comprehensive exam or advising the athletic director of the college in writing of the need for same. We appreciate your assistance and cooperation in maintaining the health of our student-athletes.

Student Name _____
(Last) (First) (Middle Initial)

Date of Birth _____ Male ❑ Female ❑ Height _____ Weight _____
Month/Day/Year

Blood pressure at rest and sitting: Left arm _____/_____ mmHG Right arm _____/_____ mmHG

Resting pulse rate: Apical _____ Radial _____

Visual acuity: Left 20/_____ Right 20/_____ Please check appropriate box: ❑ With correction ❑ Without correction

Please check appropriate box to indicate if Normal or Abnormal, and provide comments if abnormal.

SYSTEM		N	AB	COMMENTS
HEAD	Hair, scalp, masses, injuries			
EYES	Proptosis, conjunctivae, sclera, EOM, pupillary size, reaction to light, peripheral vision, fundi, gross tension to palpation			
EARS	Gross hearing to speech, drums, discharges			
NOSE	Septum, mucosa, sinuses			
THROAT/MOUTH	Teeth, tongue, tonsils, infections, lesions			
NECK	Thyroid, vessels, range of motion, adenopathy, masses, voice abnormalities			
THORAX/LUNGS	Shape, expansion, deformities, rhonchi, wheezes, rales			
HEART	PMI, sounds, thrills, murmurs, gallops, PVCs			
LYMPHATICS	Cervical, axillary			
ABDOMEN	Organ enlargement (liver, spleen, etc.), masses, tenderness, hernias, scars			
GENITALIA	Scrotum, testicles, lesions, discharge, hernias			
RECTAL (Optional)	Hemorrhoids, fissures, prostate, masses			
UPPER EXTREMITIES	Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries			
LOWER EXTREMITIES	Range of motion, joint stability, muscle strength, limitations, effusion, ecchymoses, atrophy, deformities, edema, clubbing, pulses, veins, injuries			
BACK	Flexion, extension, scoliosis, kyphosis, excessive lordosis, injuries			
NEUROLOGICAL	Cranial nerves, reflexes, motor, gait, balance, sensory			
SKIN	Texture, striae, rash, acne			
MENTAL STATUS	Affect, hostility, agitation, depression, anxiety			
COVID-19 History	History of prior infection	☐ No	☐ Yes	
Do you recommend further COVID-19 or follow up testing after moderate or severe infection? (Cardiology consult or Respiratory Consult)		☐ No	☐ Yes	
Is this individual at high risk for complications if no prior history of infection?		☐ No	☐ Yes	
If yes, were they counseled about their risks of participation in a high-risk activity?		☐ No	☐ Yes	

LABORATORY TESTS (Optional or as indicated by examination)

Urinalysis: Sugar _____ Albumin _____ Ketones _____ Other _____

Hematology: Hematocrit _____

Summary of abnormal lab work _____

If medical history indicates the need for any vaccinations or booster shots, please administer during the physical examination.

Orthopedic Diagnoses _____

_____

General Medical Diagnoses _____

_____

_____

_____

Additional findings or comments on health history/significant injuries or illnesses _____

_____

DISPOSITION **(Please check one)**

- ❑ Unrestricted activity in all sports
- ❑ No participation until _____ or until _____
  (Date) (Conditions to be met)
- ❑ May participate, but with following limitations _____
- ❑ May not participate at all for following reasons _____

Medical Provider's signature _____ Date of Exam _____

MEDICAL PROVIDER IDENTIFICATION (Please print. Stamp or label okay)

Name _____ Phone (_____) _____

Address _____ City _____ Zip _____

Mail completed form to: (COLLEGE)

NOTE: The original of this report shall be confidentially filed and maintained in the athletic department. The information shall be readily available to health care providers in event of an emergency when intercollegiate sports are conducted, both at home and away from the college.

Student Name _____
(Last) (First) (Mid. Initial