

Oklahoma Panhandle State University Sports Medicine

PHYSICAL EXAMINATION (To be completed by physician)

Date _____ Name _____ Sport _____

Blood Pressure _____ Pulse _____ Height _____ Weight _____

Vision: R 20/ _____ L 20/ _____ Corrected Yes / No

	Nml	Abnml	Comments
HEENT	()	()	_____
Cardiac	()	()	_____
Lungs	()	()	_____
Skin	()	()	_____
Abdominal	()	()	_____
Genitalia	()	()	_____
Upper Extremity Joints	()	()	_____
Lower Extremity Joints	()	()	_____
Spine & Musculature	()	()	_____

Other: _____

I certify that I have reviewed the history and examined the above student and I recommend:

	Comments
_____ Clearance with no limitations.	_____
_____ Clearance pending further evaluation or testing. (Please explain)	_____
_____ Referral to other health care professional prior to clearance. (Please explain)	_____
_____ Clearance with limitations. (Please explain)	_____
_____ Disqualified from competition. (Please explain)	_____

Continue explanation on additional sheet if needed.

Name of Examining Physician _____

Address _____

Phone () _____

Physician's Stamp

Signature _____ Date _____