

Physical Exam

Participant's Name: _____ Age: _____

To Physician:

Your careful examination and written recommendation will encourage personal fitness and safe participation in strenuous sports activities. Please complete the following physical evaluation and review medical history with participant.

Normal

Abnormal

_____	Weight: _____	_____
_____	Eyes, ears, nose and throat	_____
_____	Blood Pressure: _____/_____	_____
_____	Heart	_____
_____	OS, Lungs	_____
_____	Abdomen	_____
_____	Hernia	_____
_____	Extremities	_____
_____	Spine (posture)	_____

Medical History:

Check any of the following illnesses or symptoms that have occurred to the participant in the past or present time.

___ Asthma ___ Fainting ___ Convulsions

___ Diabetes ___ Headaches ___ Heart Trouble

___ Allergies: _____

___ Medication Allergies: _____

Signature Physician, Intern or RN

Date