

**UNIVERSITY OF SOUTHERN INDIANA
ATHLETICS PHYSICAL EXAM**

NAME: _____ SPORT: _____

SEX: _____ BIRTH DATE: _____ YEAR (CALENDAR): _____

HEIGHT: _____ WEIGHT (lbs): _____ PULSE: _____ Blood Pressure: _____

VISION: Are corrective lenses worn? Y ___ N ___

R _____ L _____ B _____ (with corrective lenses in)

Pass _____ Needs further evaluation _____

Comments: _____

GENERAL SCREENING

SYSTEM	NORMAL	ABNORMAL	COMMENTS
EYES			
EARS/NOSE/ THROAT			
HEAD/NECK			
LYMPHATICS			
THORAX			
ABDOMEN			
HEART			
LUNGS			
HERNIA			
NEURO			
OTHER			

PARTICIPATION LEVEL: (please check one)

_____ **PASS (full, unlimited participation)**

_____ **LIMITED** reason and limitations: _____

_____ **FAILED (no participation without proper follow-up care and Clearance)**

Reason: _____

PHYSICIAN NAME (please print) _____ **(MUST BE MD, DO, PA, or NP)**

PHYSICIAN SIGNATURE _____ **DATE** _____

NAME: _____ SPORT: _____

ORTHOPEDIC SCREENING

BODY PART	NORMAL	ABNORMAL	COMMENTS
NECK			
SHOULDERS			
ELBOW/WRIST/ HAND			
UPPER BACK			
LOWER BACK			
HIPS			
KNEES			
ANKLES			
FEET			
OTHER			

FLEXIBILITY/FUNCTION (please note if normal or abnormal and note any deficits in space given)

PARTICIPATION LEVEL: (please check one)

_____ **PASS** (full, unlimited participation)

_____ **LIMITED** reason and limitations: _____

_____ **FAILED** (no participation without proper follow-up care and Clearance)

Reason: _____

PHYSICIAN NAME (please print) _____ (MUST BE MD, DO, PA, or NP)

PHYSICIAN ADDRESS _____ **PHONE** _____

PHYSICIAN SIGNATURE _____ **DATE** _____