

CAPITAL UNIVERSITY PHYSICAL EXAMINATION

(Please type or print)

Athlete's Name _____ **Birth Date** _____
Last First Middle

Height _____ **Weight** _____ **Pulse** _____ **BP** ____ / ____

VA: 20/ _____ 20/ _____ 20/ _____ **Corrected:** Y N
(right eye) (Left eye) (Both eyes)

	Normal	Abnormal Findings	Description
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MEDICAL			
HEENT			
Neck			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Neuro			

MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

FLEXIBILITY			
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LOW BACK:	Smooth Curve _____	Not Acceptable _____	
GASTROCNEMIUS:	Ideal 20 _____	Minimum 10 _____	Not Acceptable _____
HAMSTRINGS:	Ideal 90 _____	Minimum 80 _____	Not Acceptable _____
ADDUCTORS:	Ideal 45 _____	Minimum 45 _____	Not Acceptable _____
QUADRICEPS:	Ideal 130 _____	Minimum 120 _____	Not Acceptable _____
ILIOPSOAS:	Normal _____	Tight _____	

Clearance

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ **Reason:** _____

Recommendations: _____

I certify that I have on this date examined this athlete and that, on the basis of the examination requested by Capital University authorities and the athlete's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this athlete to participate in supervised athletic activities. **(Note exceptions above).**

Physician's Name and Address (stamp or print) <small>If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name & address of collaborating physician or physician group:</small> _____	Examiner's Signature Date _____ Examiner's Telephone Number _____
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NOTE: Medical History and Consent Must be Completed Prior to Physical Examination