

UNIVERSITY OF SOUTHERN INDIANA ATHLETICS PHYSICAL EXAM
SCHOOL YEAR: _____

NAME: _____ **SPORT:** _____

SEX: _____ **BIRTH DATE:** _____

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)** reason: _____

PHYSICIAN NAME (please print) _____

PHYSICIAN SIGNATURE _____

DATE _____

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** reason: _____

ORTHOPEDIC PHYSICIAN NAME (please print) _____

ORTHOPEDIC PHYSICIAN SIGNATURE _____ **DATE** _____