



Athletic Physical Form

Name: _____ DOB: _____
Height: _____ Weight: _____
BP: _____ Pulse: _____

Allergies: _____

Medications: _____

Systems Check: *Please Check the Appropriate Response*

	WNL	Follow Up	Notes
Ears	_____	_____	_____
Eyes	_____	_____	_____
Nose	_____	_____	_____
Throat	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Skin	_____	_____	_____
GI/Abdomen	_____	_____	_____
MSK	_____	_____	_____
Reflexes	_____	_____	_____
Menses	_____	_____	_____

Physical Exam: _____ Pass _____ Fail

I certify that this athlete is medically cleared to participate in physical activities and athletic events without restriction.

Physician Signature

Date