Manchester University
Physical Examination for Athletic Participation

Physical Examination to be completed by a Licensed Physician, PA, or NP

Name:_____

Height:_____ **Weight:**_____lbs **Blood Pressure:**_____ **Pulse:**_____BPM

Vision: Right:_____ **Left:**_____ **Corrected:** Contacts/ Glasses **Date of Birth:** _____

ORTHOPEDIC SCREENING		**Normal**	**Abnormal**	**Specific Findings**
Neck		☐	☐	
Back		☐	☐	
Shoulder		☐	☐	
Elbow / Wrist / Hand		☐	☐	
Hip / Thigh		☐	☐	
Knee		☐	☐	
Shin / Ankle / Foot		☐	☐	

BODY SYSTEM EVALUATION		**Normal**	**Abnormal**	**Specific Findings**
Head		☐	☐	
Ears, Nose, & Throat		☐	☐	
Eyes		☐	☐	
Lungs & Chest		☐	☐	
Heart & Vascular		☐	☐	
Abdominal		☐	☐	
Neurological		☐	☐	
Genitalia / Hernia		☐	☐	
Skin		☐	☐	

Does the athlete have drug sensitivities? If so, what?_____

Is the athlete now under treatment for any medical or emotional condition?

If so, what?_____

☐ NO RESTRICTION for collegiate athletic participation

☐ RESTRICTED PARTICIPATION to: _____

Physician Name:_____ Physician Signature:_____ Date:_____

Practice Name:_____ Address:_____

Phone Number:_____ _____