PHYSICAL EXAMINATION for Kingswood Athletic Department

Student Name:_____ Birth Date: _____ Age:____ Gender: M / F

KRHS Grade: _____ KRMS Grade: _____ Grad. Year_____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Vision: R_____ L_____ Glasses Y / N Contacts Y / N

Joint	Right Side Findings	Left Side Findings
HEAD & NECK: ROM		
SHOULDER: ROM		
Joint Laxity		
ELBOW: ROM		
Joint Laxity		
WRIST: ROM		
Joint Laxity		
TRUNK: ROM		
SCOLIOSIS		
HIP: ROM		
Joint Laxity		
KNEE:ROM		
ANKLE: ROM		
Joint Laxity		
NEURO: Romberg		
Balance & Coordination		

Indicators	Normal? (circle one)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdominal Assessment: (inc. liver, spleen)	YES	NO	

Areas of concern for further treatment or rehabilitation:

_____

_____

_____

Clearance

_____ Student Athlete may participate in all sports activities

_____ Student Athlete may only participate in non contact or limited contact sports

_____ Student Athlete may participate in all or non-contact sports (please indicate) after further rehabilitation or treatment.

Physician Signature:_____ Date: _____