

Central State University Athletic Department
Pre-Participation Physical Exam

Name: _____ Date: _____

SS#: _____ - _____ - _____ Sport: _____ DOB: _____

Physical Examination

Height: _____ ' _____ " Weight: _____ lbs

B.P. _____ / _____ Pulse: _____

Vision: **R** _____ / _____ with/without glasses **L**: _____ / _____ with/without glasses

Clinical Evaluation

Check each item in the Appropriate Column	WNL	ABNL	Describe Abnormality
Skull, Scalp, Face, Neck, Thyroid			
Eyes, Ears, Nose, Throat (EENT)			
Mouth (Gingivae, Teeth)			
Lungs and Chest			
Cardiovascular			
Abdomen			
Genitalia - Hernia			
Skin and Lymphatics Glands			
Neurological			
Psychiatric			
Upper Extremities: Shoulder, Elbow/Arm Wrist, Hand, Fingers			
Lower Extremities Knee Hamstrings, Quadriceps Ankle			
Pelvis			
Spine			
Feet (flat, pain, infection)			

Cleared: _____ Cleared, Restricted: _____
Not Cleared: _____ Further Evaluation: _____

Comments: _____

Examining Physician

Date