

Physician must complete this form

Rogers Adventist School Student Athlete Physical Examination

Name: _____ Grade 3 4 5 6 7 8
Last First MI

Age: _____ Pulse: _____
Height: _____ Blood Pressure: _____
Weight: _____ Visual Acuity: Left 20/ _____
Right 20/ _____

Optional	
Urinalysis:	_____
Body Fat %:	_____
HCT:	_____
EST VO2 Max:	_____
Audiometry:	_____

	Normal	Abnormal	
1. Head	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Eyes (pupils), ENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Physical Maturity	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Spine, Back	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Shoulders, Upper extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____

Assessment: Full participation
 Limited participation (describe limitations, restrictions): _____

Participation contraindicated (list reasons): _____

Recommendations (equipment, taping, rehabilitation, etc.): _____

Date: _____ Examiner's Signature: _____
Month/Day/Year
Examiner's Phone: () - Print Examiner's Name: _____

Physical Examinations are valid for 24 months from the date of exam