

PHYSICAL FINDINGS

HEIGHT _____ (ins) WEIGHT _____ (lbs)
 PULSE _____ BLOOD PRESSURE _____

ORTHOPEDIC EXAMINATION

(To be completed by physician / athletic trainer)

ORTHOPEDIC

	WNL	ABNORMAL	COMMENTS
ROM / FLEXIBILITY:			
Neck			
Upper Extremities			
Trunk			
Lower Extremities			

SPECIAL TESTS:

Shoulder:	Gross Strength			
	Apprehension			
	Impingement			
Elbow / Wrist:	Gross Strength			
	Elbow Stress			
Spine:	Curvature			
	S-I Levels			
Knee:	Q / H Strength			
	Valgus/Varus			
	A/P Drawer			
	Lachman's			
	McMurray's			
Ankle:	Strength			
	Drawer			
Other:	Talar Tilt			

PHYSICIANS EXAM

	Normal	Abnormal	Comments
Upper extremity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lower extremity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck/Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____

General exam

	Normal	Abnormal	Comments
1.) Lungs:	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.) Heart:	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.) Abdominal	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.) Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____

ADDITIONAL COMMENTS:

ACTIVITY RESTRICTIONS:

THIS CERTIFIES THAT ON THIS DAY _____, _____ (NAME)
 WAS EXAMINED AND IS IS NOT PHYSICALLY ABLE TO PARTICIPATE IN
ALL LIMITED ATHLETIC ACTIVITIES AT HCC.
 A FOLLOW-UP EXAMINATION IS IS NOT REQUIRED. (By, _____)

Date _____

Physician's Signature _____