AUGUSTANA COLLEGE PRE-PARTICIPATION PHYSICAL EVALUATION

(Must be performed by a medical doctor or doctor of osteopathic medicine.) 12-13

Athletic Physical for_____ Sport_____ Fr So Jr Sr 5th
DOB_____ Height_____ Weight_____ Vision (R)_____(L)_____ Hearing_____
B/P (R) _____ (L) _____ Pulse_____ U/A _____
Temperature_____ Resting Heart Rate_____ Pupils Equal_____ Unequal_____

MEDICAL	**OK**	**Abnormal Findings**
ENT	( )	_____
Lungs	( )	_____
Heart	( )	_____
Reflexes	( )	_____
Hernia	( )	_____
Nodes: Neck	( )	_____
Axilla	( )	_____
Kidneys	( )	_____
Liver	( )	_____
Spleen	( )	_____
Genitalia-Males	( )	_____
MUSCULOSKELETAL		
Neck	( )	_____
Spine	( )	_____
Shoulder/Arm	( )	_____
Elbow/Forearm	( )	_____
Wrist/Hand	( )	_____
Hip/Thigh	( )	_____
Knee	( )	_____
Leg/Ankle	( )	_____
Foot	( )	_____
	( )	_____
	( )	_____

A PHYSICAL WILL BE ACCEPTED- ONLY IF ALL TESTS ARE COMPLETED

Allergies to Medications or Other:_____
Comments/Recommendations:_____
_____
_____
_____
_____

I certify that I have reviewed the history and examined the above student and I recommend:
____Clearance with no limitations
____Clearance pending further evaluation or testing.
____Referral to other health care professional prior to clearance.
____Clearance with limitations.
____Disqualified from competition.

COMMENTS:
_____
_____
_____

office stamp below

Physician's Name (print):_____Phone:_____
Address: _____
(Street) (City) (State) (Zip)
Physician's Signature _____ MD / DO **Date:_____ physical completed**