

**OUR LADY OF VICTORY CATHOLIC SCHOOL
ATHLETIC PHYSICAL EXAMINATION FORM**

Name: _____ Grade: _____ Date: _____

Sport: _____ Age: _____

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

Vision: R 20/ _____ L 20/ _____ Glasses/Contacts: Yes _____ No _____

Medical exam	Normal	Abnormal Findings	Initials
EENT			
HEART/PULSES			
LUNGS			
ABDOMEN			
GENITOURINARY			
NEUROLOGICAL			
SKIN			
OTHER			
MUSCULOSKELETAL			
NECK			
BACK			
SHOULDER/ARM			
ELBOW/FOREARM			
WRIST/HAND			
HIP/THIGH			
KNEE			
LEG/ANKLE			
FOOT			

SPECIAL TEST: (BASED ON HISTORY FORM)

RECOMMENDATION: PLEASE CHECK THE APPROPRIATE RESPONSE

_____ This student may compete with **NO RESTRICTIONS**

_____ This student may compete with the following restriction _____

_____ This student may compete **AFTER COMPLETING**
evaluation and rehabilitation for: _____

_____ This student **MAY NOT COMPETE** in an athletic activity

Signature of Examiner: _____ Date: _____

Phone number of examining physician: _____

Copies: Coach, Principal

(Revised 4-20-04)