Information below to be filled out by physician only

Height ____________ Weight ____________ Blood Pressure ____________ Pulse ____________

General Medical Exam:

	Norm	Abnl		Norm	Abnl		Norm	Abnl
ENT	____	____	Lungs	____	____	Hernia (if Needed)	____	____
Heart	____	____	Abdomen	____	____	Marfan Stigmata	____	____
Skin	____	____						

Comments ____

____

Flexibility Exam:

	LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT
Neck	____	____	Back Ext / Flex	____	____	Quads	____	____
Hips	____	____	Shoulder	____	____	Heelcords	____	____
Hams	____	____						

Comments ____

____

Orthopaedic Exam:

	Norm	Abnl		Norm	Abnl		Norm	Abnl
I. Spine / Neck	____	____	II. Upper Extremity	____	____	III. Lower Extremity	____	____
Cervical	____	____	Shoulder	____	____	Hip	____	____
Thoracic	____	____	Elbow	____	____	Knee	____	____
Lumbar	____	____	Wrist	____	____	Ankle	____	____
			Hand / Fingers	____	____	Feet	____	____

Other Comments ____

____

Optional Exams:

DENTAL

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

VISION L________ R________

Comments: ____

____

Comments ____

[ ] **From this limited screening I see no reason why this student cannot participate in athletics**

[ ] **Student needs further evaluation as described**

________________________________ ________________________________, M.D.

Typed or Printed Name of Physician SIGNATURE OF PHYSICIAN

DO NOT FOLD FORM

MSMOC 62 Rev. March 2016