

Student Name _____

PHYSICAL EXAMINATION

BP _____ P _____ W _____ HT _____ Vision (R) _____ (L) _____

WRESTLING: I recommend that the pupil designated above should not be allowed to wrestle any weight less than the indicated classification Circling:

103	112	119	125	130	135	140	145	152	160	171	189	215	275
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Normal Abnormal

- | | | | |
|--------------------------|--------------------------|----|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | A. | HEENT |
| <input type="checkbox"/> | <input type="checkbox"/> | B. | Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | C. | Lungs |
| <input type="checkbox"/> | <input type="checkbox"/> | D. | Abdomen |
| <input type="checkbox"/> | <input type="checkbox"/> | E. | Hernia (males only) |
| <input type="checkbox"/> | <input type="checkbox"/> | F. | Knee* |
| <input type="checkbox"/> | <input type="checkbox"/> | G. | Ankle* |
| <input type="checkbox"/> | <input type="checkbox"/> | H. | Shoulder* |
| <input type="checkbox"/> | <input type="checkbox"/> | I. | Other Joints* |
| <input type="checkbox"/> | <input type="checkbox"/> | J. | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | K. | Feet |
| <input type="checkbox"/> | <input type="checkbox"/> | L. | Estimate of strength |
| <input type="checkbox"/> | <input type="checkbox"/> | M. | Estimate of flexibility |

Description of Abnormal Findings

*(Record laxity, weakness, instability, decreased ROM—if abnormal)

ASSESSMENT

- A. No problems identified
- B. Other

RECOMMENDATIONS

- A. Unlimited
- B. Limited to specific sports: _____
- C. Deferred until: _____
(eg. rehabilitation, recheck, consultation, laboratory tests, etc.)
- D. Disqualified

REEXAMINE

- A. Yearly and after any injury that limits participation for longer than one week
- B. Other

Physician Signature _____ Date _____

Physician Name _____ Physician Phone _____
(Please Print)

Address _____