|  |  |
| --- | --- |
|  | DATE OF PHYSICAL EXAM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| **NEUMANN UNIVERSITY PHYSICAL EXAMINATION FORM** |
| IF PLAYING A SPORT THIS FORM MUST BE SIGNED BY A **MD or DO**, NOT NURSE PRACTITIONER OR PHYSICIAN ASSISTANT, etc. |
| Status: FR SO JR SR GRAD | Sport (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NUID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
| Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  street | city | state | zip code  |
| \*\*\*\*\*\*\*\*(below is for physician to complete) \*\*\*\*\*\*\*\* |
| **PHYSICAL EXAMINATION:** |  |  |
| Blood Pressure: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Heart Rate: \_\_\_\_\_\_\_\_\_\_ SpO2: \_\_\_\_\_\_\_\_\_\_ | Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs. |
|   | **NORMAL** | **ABNORMAL** | **COMMENTS** |
| Head |   |   |   |
| Eyes |   |   |   |
| Ears |   |   |   |
| Nose |   |   |   |
| Throat |   |   |   |
| Neck |   |   |   |
| Chest/Lungs |   |   |   |
| Heart |   |   |   |
| Abdomen |   |   |   |
| Skin |   |   |   |
| Neurological |   |   |   |
|   |   |   |   |
| **ORTHOPAEDIC EXAM** | **RIGHT** | **LEFT** | **COMMENTS** |
| Ankle |   |   |   |
| Knee |   |   |   |
| Hip |   |   |   |
| Back |   |   |   |
| Shoulder |   |   |   |
| Elbow |   |   |   |
| Wrist/Hand |   |   |   |
|  |  |  |  |
| CLEARED FOR ATHLETIC PARTICIPATION: (Please Circle) YES NO |
|  |   |  |  |
| Physician's Office Stamp or Printed Name & Phone Number |  |
|   |   |
| Physician's Signature/Date |