|  |  |  |  |
| --- | --- | --- | --- |
|  | 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 | |