

University of St. Francis
Department of Sports Medicine
Physical Form

Name: _____ Sport: _____

SS#: _____ Date of Birth: _____ Sex: M F

Height: _____ Weight: _____ BP: _____ Pulse: _____

	WNL		Abnormal		Comment:
	L	R	L	R	
<u>Shoulder:</u>					
AROM					
Subluxation					
Wrist/Hand/Finger					
Elbow					
<u>Back and Neck</u>					
Back AROM					
Neck AROM					
SLR					
<u>Knee</u>					
Ligament Laxity					
Hamstring Strength					
Hamstring Flexibility					
MacMurry Test					
<u>Foot and Ankle</u>					
Heel Cord					
Strength					
Drawer Test					

	Normal	Abnormal
Eyes		
Ears		
Mouth/Throat		
Nose		
Heart		
Lungs		
Abdominal		
Genitalia/Hernia		
Skin		

This athlete is CLEARED for participation in intercollegiate athletic: _____

This athlete is NOT CLEARED for participation in intercollegiate athletic: _____

If not cleared, advise plan treatment:

Physician Signature: _____ Date: _____

Type or print name of physician (Prefer MD office stamp):

Office Phone: _____