

GW Graham Athletics

Football

PHYSICAL EXAMINATION : TO BE COMPLETED BY PHYSICIAN

Students Name _____

Birth date _____ PHN: _____

Height _____ Weight _____ BMI : _____

Pulse _____ BP L arm _____ / _____ R Arm: _____ / _____

Vision (with glasses Y or N) R ___/___ L ___/___ Both ___/___

Any **abnormalities on history or exam**:

Appearance	Yes	No	MSK	Yes	No
ENT			Head and Neck		
Skin			Shoulder/Upper Arm		
Heart including murmurs			Wrist/Hand/Elbow		
Lungs			Back		
Abdomen			Hip / Knee		
GU			Feet		
History of Concussion / Head injury			<i>Details of Concussion including Year and Activity:</i>		

Details from any YES`:` _____

Medical History that would **preclude** participation in Football:

PLEASE CHOOSE ONE OF THE FOLLOWING:

1) **Cleared without restriction**

2) **Cleared, with recommendations for further evaluation or treatment of:**

3) **Not cleared**

Recommendations: _____

Name of Physician: (print/type/stamp)

Name: _____

Date: _____

Physician Signature