

SPORT OF PARTICIPATION

# Biola University Athletics Preparticipation Sports Physical Examination

PLEASE LIST  
DRUG ALLERGIES

Name (LAST, FIRST, MI) \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex: M F Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ B/P: (L) \_\_\_\_\_ (R) \_\_\_\_\_

Vision: L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_ Both 20/ \_\_\_\_\_ Corrected: Y N Pupils Equal? Y N

| <u>MEDICAL</u>                              | NORMAL  | ABNORMAL FINDINGS |
|---|---------|-------------------|
| Appearance/Emotional Affect                 |         |                   |
| Eyes/Ears/Nose/Throat                       |         |                   |
| Lymph Nodes                                 |         |                   |
| Heart                                       |         |                   |
| Pulses                                      |         |                   |
| Lungs                                       |         |                   |
| Abdomen                                     |         |                   |
| Genitalia (Males only)                      |         |                   |
| Breasts (Females only)                      |         |                   |
| Skin  |         |                   |
| <b>LAB (Must be completed):</b> UA: Glucose | Protein | Hct or Hgb:       |
| <u>MUSCULOSKELETAL</u>                      |         |                   |
| Neck  |         |                   |
| Back  |         |                   |
| Shoulder/Arm                                |         |                   |
| Elbow/Forearm                               |         |                   |
| Wrist/Hand                                  |         |                   |
| Hip/Thigh                                   |         |                   |
| Knee  |         |                   |
| Leg/Ankle                                   |         |                   |
| Foot  |         |                   |

### CLEARANCE

Cleared  Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not Cleared Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

SIGNATURE OF M.D. \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_  
OFFICE STAMP \_\_\_\_\_

PRINTED NAME \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

*Adopted from the 1997 American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.*