COLTS PHYSCIAL EXAMINATION FORM *DATE:* _____

NAME_____ SECTION_____

PHONE_____ EMAIL_____

ADDRESS_____ SEX_____

CITY, STATE, ZIP_____ BIRTHDATE_____

Age____ Height (in):_____ Weight (lbs.):___ BP_____/_____ Pulse___

Vision R 20/____ L 20/___ Glasses or Contacts? (Circle)
Significant past illness OR injury:_____
_____

Date:	Normal	Abnormal Findings/Comments
Cardiovascular		
Respiratory		
Skin		
Neurological		
Abdominal		
Genitalia/Hernia		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back/Spine		
Knee		
Ankle		
Foot		
Other		

Laboratory Tests Performed with results: _____

Allergies/Hypersensitivities: _____

Please attach complete immunization list_____

Clearance: Cleared, no restrictions
Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____

For the following reason(s): _____

Recommendation: _____

Print name of Physician: _____

Physician Address: _____

Physician Phone: _____

Signature of physician_____