LURLEEN B. WALLACE COMMUNITY COLLEGE

TO BE COMPLETED BY EXAMINING PHYSICIAN

Name of Athlete: _____

Height: _____ **Weight:** _____ **BP:** _____/_____ **Pulse:** _____

Vision: **RIGHT:** 20/_____ **LEFT:** 20/_____ **Corrected:** Yes / NO

	Normal	**Abnormal Findings**
Cardiovascular		
Pulses		
Heart		
Lungs		
Skin		
E.N.T.		
Abdominal		
Genitalia (Males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
hand		
Back		
Knee		
Ankle		
Foot		
Other		

Clearance

_____ Cleared **(No Restrictions)**

_____ Cleared after completing evaluation/rehabilitation for:

_____

_____ Not cleared for:

_____ Collision
_____ Contact
_____ Non-Contact
_____ Strenuous
_____ Moderately Strenuous
_____ Non-Strenuous

DUE TO: _____

Recommendation: _____

_____

Name of Physician: _____ **Title:** _____

Address: _____ **Phone:** ( ) _____

Physician Signature: _____ **Date:** _____