Saint Xavier University Health Center
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PRE-PARTICPATION SPORTS PHYSICAL

PHYSICAL EXAM (SXU Athlete)

Name_____Date of birth_____ □Male □ Female

Height_____	BP_____ Pulse_____	Vision: Right 20/ Left 20/
	Resp_____ Temp_____	□Corrected □Uncorrected
Weight_____	SpO2 (optional)_____	Allergies_____

Medical	**Normal**	**Abnormal Findings**
Appearance -*Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency) –Mood -General appearance*		
Eyes/ears/nose/throat *-PERRLA -EOMI -Hearing intact –Oropharynx WNL -*		
Lymph nodes/Thyroid		
Heart *(S1S2, RRR)* *-Murmurs (auscultation standing, supine, +/- valsalva)* *-Location of point of maximal impulse (PMI)*		
Pulses *-Simultaneous femoral and radial pulses*		
Lungs *(CTA)*		
Abdomen *(+BS, no masses/organomegaly to palpation)*		
Skin *-no HSV, lesions suggestive of MRSA, tinea corporis*		
Neurologic *(CNII-XII intact, UE/LE reflexes equal and intact)*		
Musculoskeletal (Full ROM, strength)		
Neck		
Back/spine		
Shoulder/Arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional *-Duck-walk, single leg hop*		

□Cleared for all sports without restriction
□Cleared for all sports without restriction with recommendations for further evaluation or treatment for_____
_____

□Not cleared

□Pending further evaluation □For certain sports_____

□For any sports Reason_____

Recommendations_____
_____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and has been given to the patient. If conditions arise after the athlete has been cleared for participations, the provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete.

Name of provider (print)_____ Date_____
Address_____ Phone_____

Signature of provider_____MD/DO/NP/PA