CATHEDRAL CATHOLIC DONS ATHLETICS

ATHLETIC PHYSICAL FORM
2024-2025

(Exam MUST be completed on or after Friday, June 7, 2024)

**Must be completed by a Physician (MD/DO), Physician's Assistant (PA), or Nurse Practitioner (NP), licensed in the State of California.*

NAME: **GRADE:** **DATE OF EXAM:**

DATE OF BIRTH:		SEX: ☐ MALE / ☐ FEMALE
HEIGHT:	WEIGHT:	BMI:
SPORTS:		

VITAL SIGNS

BLOOD PRESSURE:	PULSE:	RESPIRATIONS:

VISION

RIGHT EYE:	LEFT EYE:	PERL:
TESTED WITH CORRECTIVE LENSES: ☐ YES ☐ NO	☐ GLASSES ☐ CONTACTS	

PHYSICAL EXAM

	NORMAL	*ABNORMAL*	*COMMENTS*
APPEARANCE/SKIN			
EYES/EARS/NOSE/THROAT			
HEAD/NECK/LYMPHATICS			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL/URINARY			
MUSCULOSKELETAL			
NEUROLOGICAL			

PHYSICIAN CLEARANCE (*MUST check one*)

	CLEARED FOR UNLIMITED PARTICIPATION / NO RESTRICTIONS	
	LIMITED PARTICIPATION	*EXPLAIN*:
	WITHHELD FROM PARTICIPATION	*EXPLAIN*:

I have reviewed the medical history and given a thorough physical examination to the above-named student. I certify that all the important medical information has been included, and the information is complete and accurate.

PHYSICIAN'S SIGNATURE: **DATE:**

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PHYSICIAN'S NAME (printed): **PHONE NUMBER:**

PHYSICIAN'S STAMP or BUSINESS CARD (REQUIRED):

ROLL DONS