

Preparticipation Physical Examination for COC Intercollegiate Athletes

PHYSICAL EXAMINATION

***MUST BE COMPLETED & SIGNED BY A LICENSED MD or DO. NP & PAC may complete as long as MD or DO signs off. DC not accepted.**

Name _____	Date of birth _____
Height _____	Weight _____
Pulse _____	BP _____ / _____ (_____/_____, _____/_____)
Vision R 20/_____ L 20/_____	Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip (thigh)			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician (MD or DO) _____

CONSENT TO TREAT

The undersigned athlete/patient hereby consents to and authorizes any physician, athletic trainer, or medical personnel to administer and perform any and all medical examinations, treatments, designated procedures, and dispense medication which may be now or during the course of the athlete/patient's care as an outpatient be deemed advisable or necessary.

The undersigned also consents to the release of medical information to other institutions accepting the athlete/patient for medical care relative to continuity of the care for this visit. A photo static copy of this authorization shall be considered as effective and valid as the original.

Athlete/Patient Signature _____ Date _____