PHYSICAL EXAMINATION FORM (COMPLETED BY DOCTOR)

NAME:_____ BIRTHDATE:_____/_____/_____

Height:_____ Weight:_____ % Body Fat(optional): _____ Pulse: _____ BP:_____/_____ (_____/_____, _____/_____)

Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal_____ Unequal_____ Rhythm: Regular_____ Irregular_____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart: Pericardial activity			
1st and 2nd heart sounds			
Murmurs			
Pulses: brachial/femoral			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

*Station-based examination only

_____ Cleared

_____ Cleared after completing evaluation/rehabilitation for: _____

_____ Not cleared for: _____ Reason: _____

Recommendations: _____

_____

Name of Physician (print/type): _____ Date: _____/_____/_____

Address: _____ Phone: (_____)_____

Signature of Physician:_____

As per ORS 336.479, Section 1 (5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in d