PHYSICAL EXAMINATION (To be completed by a Physician. Physical must be dated 6/1/17 or later.)

Athlete's Name: _____ Sport: _____

Date of Birth: _____

Height: _____ Weight: _____

Pulse: _____ Blood Pressure _____/_____

Clinical Evaluation:

Normal	Abnormal	*Check each item in appropriate column.*
		1. HE ENT
		2. LUNGS and CHEST
		3. HEART
		4. ABDOMEN/hernia
		5. G-I SYSTEM
		6. MUSCULOSKELETAL
		7. SKIN, LYMPHATIC GLANDS
		8. NEUROLOGIC
		9. PSYCHIATRIC (specify any known treatment of mental illness/depression, personality disorders, etc.)

Notes: Describe any abnormality:

_____

_____

Is this student able to compete in varsity athletics for the 2017-2018 academic year? ____Yes ____ No
If NO, please explain below:

Recommendations/ Restrictions (lifting, sports, etc)

_____

_____

_____

_____ _____

Signature of Physician Address

_____ _____

Please Print Physicians Name City/State/Zip

_____ _____

Date of physical exam Telephone Number

IOWA WESTERN

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