ATHLETIC EXAMINATION FORM – SPIRIT SQUADS
Iowa State University

Name _____ SS# _____

Pulse Rate _____ Temp. _____ Height _____ Weight _____ BP _____

Vision R20/_____ L/20_____ Corr. R20/_____ L/20_____ Color vision _____

Immunization dates Measles or MR _____ TB or Tetanus _____ International TB _____

Physical Exam (Please elaborate on **any** abnormality reported in the history)

	N	ABN	Describe abnormality in detail
Head, face, and scalp			
Mouth, nose & throat (nasal septal deviation)			
Tonsils ( ) in or ( ) out			
Ears (T.M.'s, hearing)			
Eyes (PERRLA, EOMI)			
Neck (thyroid)			
Lymph nodes			
Lungs and chest			
Breasts			
Heart (RRR without murmur)			
Vascular system (pulses, varicosities, etc.)			
Abdomen (include hernia)			
Genitalia			
Anus – Rectal (as indicated)			
Pelvic (as indicated)			
Musculoskeletal (strength & range of motion)			
Neck			
Shoulders			
Elbows			
Hands/wrists			
Spine/Pelvis/Hips			
Knees			
Ankles			
Feet			
Skin			
Neurologic			
Psychiatric – if indicated			

Lab results: Hgb _____ Hct _____ Cholesterol _____ Sickle Cell

Urine SP Gr _____ Protein _____ Glucose ___ Micro

Assessment:

Recommendations/preventive measures:

Clearance (Check appropriate category):

☐ No restrictions to contact/collision

☐ Limited contact/impact

☐ No – contact

☐ Strenuous ☐ Non-strenuous

☐ Clearance deferred until seen by team physician or specialist

Physician's Name (print) _____

Physician's Signature _____

Month/Day/Year _____