

PHYSICAL EXAMINATION

Age: _____ Pulse: _____
Height: _____ Blood Pressure: _____
Weight: _____ Visual Acuity: Left 20/ _____
Right 20/ _____

**As per the WIAA Regulations,
physicals are good for 24 months**

Optional
Urinalysis:
Body Fat %
HCT:
EST VO2 Max:
Audiometry:

Normal		Abnormal
<input type="checkbox"/>	1. Head	<input type="checkbox"/> _____
<input type="checkbox"/>	2. Eyes (pupils), ENT	<input type="checkbox"/> _____
<input type="checkbox"/>	3. Teeth	<input type="checkbox"/> _____
<input type="checkbox"/>	4. Chest	<input type="checkbox"/> _____
<input type="checkbox"/>	5. Lungs	<input type="checkbox"/> _____
<input type="checkbox"/>	6. Heart	<input type="checkbox"/> _____
<input type="checkbox"/>	7. Abdomen	<input type="checkbox"/> _____
<input type="checkbox"/>	8. Genitalia	<input type="checkbox"/> _____
<input type="checkbox"/>	9. Neurologic	<input type="checkbox"/> _____
<input type="checkbox"/>	10. Skin	<input type="checkbox"/> _____
<input type="checkbox"/>	11. Physical Maturity	<input type="checkbox"/> _____
<input type="checkbox"/>	12. Spine, Back	<input type="checkbox"/> _____
<input type="checkbox"/>	13. Shoulders, Upper extremities	<input type="checkbox"/> _____
<input type="checkbox"/>	14. Lower extremities	<input type="checkbox"/> _____

Assessment: Full Participation
 Limited participation (describe limitations, restrictions):

Participation contraindicated (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

Date: _____ EXAMINER'S SIGNATURE: _____

Examiner's Phone () _____ PRINT EXAMINER'S NAME: _____

*Must be **signed and dated** by a doctor of medicine, osteopathy, or naturopathy, a Physician's Assistant, or an Advanced Registered Nurse Practitioner (ARNP) as per WIAA requirements.*