

University of Vermont Athletic Medicine
STUDENT ATHLETE PRE-PARTICIPATION PHYSICAL EXAMINATION
 97 Spear St, 140 Patrick Gym Burlington, VT 05405
 (802) 656-7750 fax (802) 656-9578

Name _____	95# _____	Date of Birth _____	Sport _____
Height _____	Weight _____	Pulse _____	BP ____/____
Vision R 20/____	L 20/____	Corrected Y N	Pupils: Equal____ Unequal____

	Normal	Abnormal Findings
Medical		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only) *OPTIONAL*		
Skin		
Neurologic		
Musculoskeletal		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Ankle		
Foot		

Sickle Cell Trait Lab Result (*DOCUMENTATION REQUIRED*)

Positive Negative

Medications

Clearance

Cleared
 Cleared after completing evaluation/rehabilitation for: _____

 Not Cleared Reason _____

Recommendations: _____

Name of Physician: _____

Signed: _____ Date _____