

# Health Checklist

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

SID: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_

## PHYSICIAN USE ONLY

GENERAL	NORMAL	ABNORMAL
EENT		
Mouth/Teeth		
Ears, Nose, Throat		
Thyroid		
Lymph Nodes		
Skin		
Lungs		
Heart		
Abdomen		
Extremities		
Genitalia/Hernia		
Reflexes		

MUSCULOSKELETAL	NORMAL	ABNORMAL
ROM - Strength, etc		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back/Spine		
Knee		
Ankle		
Foot		

NEUROMUSCULAR	NORMAL	ABNORMAL

RECOMMENDATIONS

Name of Athlete: \_\_\_\_\_

Cleared for participation: Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ please print \_\_\_\_\_ Date \_\_\_\_\_