

Name	Social Security Number	Date
WCU Medical Notes:		Sport

Clinic Information

Clinic Name	Clinic Stamp
Address	
Phone Number	
Attending Physician's Name	

Information below to be filled out by physician only

General Information

Height:	Vision:	Blood Pressure:
Weight:	Wears: Contacts / Glasses / N/A	Pulse:
Comments:		

Orthopedic Exam

Norm	Abnl	Spine / Neck	Norm	Abnl	Upper Extremity	Norm	Abnl	Lower Extremity
<input type="checkbox"/>	<input type="checkbox"/>	Cervical	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Hip
<input type="checkbox"/>	<input type="checkbox"/>	Thoracic	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Knee
<input type="checkbox"/>	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Ankle
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Hand / Fingers	<input type="checkbox"/>	<input type="checkbox"/>	Feet
			<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
Comments:								

General Medical Exam

Norm	Abnl		Left	Right	Flexibility
<input type="checkbox"/>	<input type="checkbox"/>	ENT	<input type="checkbox"/>	<input type="checkbox"/>	Neck _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Hips _____
<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Hams _____
<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Back Ext / Flex _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder _____
<input type="checkbox"/>	<input type="checkbox"/>	Hernia (if needed)	<input type="checkbox"/>	<input type="checkbox"/>	Quads _____
			<input type="checkbox"/>	<input type="checkbox"/>	Heelcords _____
Comments:					

- From this limited screening, I see no reason why this student cannot participate in collegiate athletics.
- Student needs further evaluation as described

_____, *M.D.* _____
 Typed or Printed Name of Physician Signature of Physician Date