TEXAS TECH UNIVERSITY ATHLETIC PHYSICAL

NAME_____ SEX _____ AGE_____ DATE OF BIRTH _____

R NUMBER _____ SPORT _____

SIGNATURE: _____ DATE OF EXAM: _____

_____

_____

MEDICAL/PHYSICAL EXAM:

HEIGHT _____ WEIGHT _____ BP_____/_____ PULSE _____

VISION: RIGHT 20/_____ LEFT 20/_____ CORRECTED YES / NO DENTAL: WNL F/U

	NORMAL	ABNORMAL FINDINGS
Heart		
Pulses		
Lungs		
E.N.T.		
Abdomen		
Genitalia (Males)		
Musculoskeletal		

CLEARANCE:

A. Cleared

B. Cleared after completing evaluations/rehabilitation for:_____

C. Not Cleared Due To: _____

Recommendation:_____

_____

Name of Physician:_____ Date: _____

Address:_____ Phone: _____

Signature of Physician:_____ M.D. or D.O.