



Averett University
Athletic Training Department

Medical Examination for Intercollegiate Athletics

Name: _____ Class: FR SO JR SR
Social Security #: _____ Date of Birth: _____ Sex: M F

Please circle the sport(s) in which the student-athlete participates:
Baseball Basketball Cheerleading Cross Country Football
Golf Lacrosse Soccer Softball Tennis Volleyball

Have you had a significant illness or injury? _____ If YES, please explain in detail _____

Have you ever had surgery? _____ if YES, please explain in detail _____

The following is to be completed by a physician

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Eyes: (Corrected/Uncorrected) Right: _____ Left: _____
If corrected, glasses or contacts? _____

Ears: Right: _____ Left: _____

Physical Exam:

Respiratory: _____ Cardiovascular: _____ Abdomen: _____

Musculoskeletal: _____ Neurological: _____

Medications: _____

Cleared for participation: _____ Not cleared for participation: _____

Further exam required: _____ Recommendations: _____

Date of Exam: _____ Physician's Name & Address: _____

Telephone: () _____

Fax: () _____

Physician's Signature: _____



**Averett University
Athletic Training Department**