

Jim McLaughlin Volleyball Camp
Pre-participation Physical Evaluation

Today's Date _____

Name _____	Date of Birth _____
Height _____	Weight _____
Pulse _____	BP ____/____ (____/____, ____/____)
Vision R 20/____ L 20/____	Corrected: Y N (contacts/ glasses) Pupils: Equal____ Unequal ____

INITIALS NORMAL ABNORMAL FINDINGS

MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/ Arm			
Elbow/ Forearm			
Wrist/ Hand			
Hip/ Thigh			
Knee			
Leg/ Ankle			
Foot			

<input type="checkbox"/> Cleared	
<input type="checkbox"/> Cleared after completing evaluation/ rehabilitation for: _____	

<input type="checkbox"/> Not cleared for (Reason/ Recommendations): _____	

<input type="checkbox"/> Restrictions _____	
<input type="checkbox"/> Allergies _____	
Name of physician (print/type) _____ Phone _____	
Address _____	
Signature of physician _____, MD or DO	Date _____