

**OLD DOMINION UNIVERSITY
ATHLETIC PHYSICAL EXAMINATION FORM**

Name: _____	SSN: _____	Sport: _____
Date: _____	Circle Year In School: Freshman – Sophomore – Junior - Senior	
Height: _____	Weight: _____	Pulse: _____ Blood Pressure: _____

VISION CHECK

Right Eye: _____	Left Eye: _____	Physician's Initials: _____
Follow-up Needed: YES NO Comments: _____		

ENT CHECK

Ears: _____	Nose: _____
Throat: _____	Neck: _____
Follow-up Needed: YES NO What Test(s)? _____	
Physician's Initials: _____	

INTERNAL CHECK

Heart: _____	Lungs: _____
Abdomen: _____	Hernia: _____
Follow-up Needed: YES NO What Test(s)? _____	
Physician's Initials: _____	

ORTHOPEDIC CHECK

Comments: _____
Follow-up Needed: YES NO What Test(s)? _____
Physician's Initials: _____

DENTAL CHECK

Comments: _____
Follow-up Needed: YES NO What Test(s)? _____
Physician's Initials: _____

URINE CHECK

Positive: _____ Negative: _____	Attendant's Initials: _____
Follow-up Needed: YES NO	

**TWO LEGGED DROP
JUMP TEST**

Positive: _____ Negative: _____	Comments: _____	Attendant's Initials: _____
Follow-up Needed: YES NO		