



**Catholic Youth Organization**  
 580 E. Stevens Street  
 Indianapolis, IN 46203  
 (317) 632-9311 F(317) 632-8767

**Athletic Physician Certificate**

**This form is to be turned in to the Team Coach or Athletic Director  
 and is to be kept on file at the Parish or School.**

**Physical Examination**

**Date** \_\_\_\_\_

Name of Athlete/Camper \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height _____ Weight _____ BP _____ / _____ Pulse _____		
Vision: R 20/ _____ L 20/ _____ Corrected: Y N Pupils (Circle) Equal / Unequal R > L L > R		
	Circle (if option given)	Specific Findings
Marfan's syndrome stigmata	No Yes	
<b>Heart</b>		
Rhythm	Regular Irregular	
Murmur (supine)	No Yes	
Murmur (standing)	No Yes	
	Normal <input type="checkbox"/>	Specific Findings
Lungs		
Skin		
Abdominal		
Femoral Pulses		
Genitalia / Hernia		
<b>Musculoskeletal:</b>		
Neck		
Shoulders		
Elbows		
Wrists		
Hands		
Back		
Knees		
Ankles		
Feet		
Other		

Continued



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1. Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- C. Not Cleared  
 Due to: \_\_\_\_\_

Recommendation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. I hereby certify that this athlete/camper was examined by me. At this time, no physical condition was detected which reasonably be anticipated to render this athlete physically unfit to engage in any sport, except those marked below:

- Boys Sports:** Baseball, Basketball, Cross Country, Football, Soccer, Track, Wrestling
- Girls Sports:** Basketball, Cross Country, Soccer, Softball, Track, Volleyball, Kickball

\_\_\_\_\_ Date

\_\_\_\_\_  
 Name of Physician

\_\_\_\_\_  
 Address City ST Zip

Phone (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
 Signature of Physician