

Oakland City University PRE-PARTICIPATION PHYSICAL EXAM (PPE)

(To be completed by your health care provider)

Examiner: This information will be used to screen athletes for participation in **Intercollegiate Athletics**, and may be shared with the athletic training and sports medicine personnel with proper authorization by the student. Please review and initial the health history form, complete this form, indicate whether or not the student should be cleared for physical activity, and sign and date the form.

Students Name: _____

Birth date: _____/_____/_____

Last
First
Middle
Day
Month
Year

MEDICAL EXAMINATION:				Left	Right
BP: _____	P: _____	Height (inches): _____			
R: _____	T: _____	Weight (lbs.): _____		Vision Corrected/	
_____	_____	Lab(s)[if applicable] _____		Uncorrected: _____	_____
				_____	_____

PHYSICAL EXAM:	Normal	Abnormal		PHYSICAL EXAM:	Normal	Abnormal	
General:				Abdomen:			
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Organs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Affect	<input type="checkbox"/>	<input type="checkbox"/>	_____	Masses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tender	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEENT:				Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal Screen:			
Anisocoria	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	_____
PERRLA	<input type="checkbox"/>	<input type="checkbox"/>	_____	Elbows	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fundi	<input type="checkbox"/>	<input type="checkbox"/>	_____	Wrists/Hands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____	Back	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hips	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Quads/hams	<input type="checkbox"/>	<input type="checkbox"/>	_____
Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Knees	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck:				Ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruits	<input type="checkbox"/>	<input type="checkbox"/>	_____	Feet	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heel/toe	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____	Duck walk	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs:				Neuro:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart:				Females:			
Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	_____	Breasts (if done)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pelvic (if done)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peripheral pulses	<input type="checkbox"/>	<input type="checkbox"/>	_____	Males:			
				Testicular	<input type="checkbox"/>	<input type="checkbox"/>	_____

ASSESSMENT / PLAN:
1. General health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
2. Immunizations up to date? <input type="checkbox"/> Td in past 10 years <input type="checkbox"/> MMR (two doses documented) <input type="checkbox"/> TB risk screened
3. Reviewed Health History form? <input type="checkbox"/>
4. Clearance for physical activity (NCAA sports, club sports, intramurals, PE) <input type="checkbox"/> Cleared <input type="checkbox"/> Limited <input type="checkbox"/> Not cleared If not cleared, please specify _____
5. Examiner's comments / other recommendations: _____ _____

_____	_____	Date: _____/_____/_____
Print examiner's name and title	Examiner's signature	Month Day Year
Address: _____	Telephone: _____	