

**Bowie State University**  
**Pre-Participation Physical Exam**

*(To be completed by Student Athlete)*

Sport(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*(To be completed by certifying physician)*

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Significant Past Illness/Injury \_\_\_\_\_

Respiratory \_\_\_\_\_ Cardiovascular \_\_\_\_\_

Liver \_\_\_\_\_ Spleen \_\_\_\_\_ Hernia \_\_\_\_\_

Musculoskeletal \_\_\_\_\_ Skin \_\_\_\_\_ Neurological \_\_\_\_\_

Genitalia \_\_\_\_\_

Laboratory: Urinalysis \_\_\_\_\_ Differential \_\_\_\_\_

Comments: \_\_\_\_\_

Completed Immunizations: Tetanus \_\_\_\_\_ Other \_\_\_\_\_

I certify that I have on this date examined this student and find him/her physically able to compete in the supervised activities not crossed out below:

Baseball	Football	Tennis
Basketball	Golf	Track
Cheerleading	Softball	Volleyball
Cross Country	Soccer	Wrestling

Date of Examination \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Telephone# \_\_\_\_\_