

Physical Examination

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____/_____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

Normal

Abnormal Findings

Initials*

MEDICAL

Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		

MUSCULOSKELETAL

Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

*Station-based examination only

Clearance

- Cleared
 Cleared after completing evaluation/rehabilitation for: _____

- Not cleared for: _____ Reason: _____
 Recommendations: _____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (Note exceptions above).

Physician's Name and Address (stamp or print)
 If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Examiner's Signature _____ Date _____

Examiner's Telephone Number _____

NOTE: History and Consent Must be Completed Prior to Physical Examination