**Office Use Only**: Date Registered: _____ Physical Date Entered: _____

## Physical Examination – ***Please Print***

Student's Name: _____
Last First Middle

Address: _____
Street City Zip

Birth Date: _____ M / F Graduating Year_____ HS Attended Last Year: _____

Parent/Guardian Name: _____ Cell #:_____

Email Address: _____

***To Be Completed by Physician:***

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

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

| **MEDICAL:** | **Normal** | **Abnormal Findings** | **Initials** |
|---|---|---|---|
| Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |

| **MUSCULOSKELETAL:** | **Normal** | **Abnormal Findings** | **Initials** |
|---|---|---|---|
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |

Station-based examination only

**CLEARANCE:**

____ Cleared
____ Not Cleared for:_____ Reason: _____
____ Cleared after completing Evaluation/Rehabilitation for:_____

Evaluation/Rehabilitation Completed: _____
Physician's Signature Date

Final Clearance: _____
Original Examining Physician's Signature Date

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 exception above)

_____ **Phone #:** _____

_____

_____ _____

**Physician's Name, Address (stamp or print)** **Examiner's Signature DATE**

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:

Revised: 2/4/16