**PHYSICAL EXAMINATION:**

**STUDENT’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SEX \_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It **must** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **\* Local district policy may require an annual physical exam.**

**This column is to be completed by Physician, Physician Assistant, Nurse Practitioner or Doctor of Chiropractic:**

**Height\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_ Pulse\_\_\_\_\_\_ BP\_\_\_\_\_/\_\_\_\_\_\_ Vision: R 20/\_\_\_\_\_\_\_\_\_\_ L 20/\_\_\_\_\_\_\_\_**

**Pupils: Equal \_\_\_\_\_\_ Unequal \_\_\_\_\_\_\_\_ Corrected: Y N**

|  |  |  |
| --- | --- | --- |
| **Medical** | **Normal** | **Abnormal** |
| **Appearance** |  |  |
| **Eyes / Ears / Nose / Throat** |  |  |
| **Lymph Nodes** |  |  |
| **Heart Auscultation (Supine)** |  |  |
| **Heart Auscultation (Standing)** |  |  |
| **Heart Lower extremity pulses** |  |  |
| **Pulses** |  |  |
| **Lungs** |  |  |
| **Abdomen** |  |  |
| **Genitalia (Males Only)** |  |  |
| **Skin** |  |  |
| **Musculoskeletal** | **Normal** | **Abnormal** |
| **Neck** |  |  |
| **Back** |  |  |
| **Shoulder / Arm** |  |  |
| **Elbow / Forearm** |  |  |
| **Wrist / Hand** |  |  |
| **Hip / Thigh** |  |  |
| **Knee** |  |  |
| **Leg / Ankle** |  |  |
| **Foot** |  |  |

# THE ABOVE STUDENT ATHLETE IS:

* CLEARED WITH NO RESTRICTIONS
* CLEARED AFTER EVAULATION FOR THE FOLLOWING

Findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* NOT CLEARED FOR PARTICIPATION

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

Name (print/type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTHCARE PROVIDER’S STAMP**