

**PRE-PARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM**

(This form is to be completed by the physician. Submit original to school Athletics Office. Physician should retain a copy.)

Student Name:	Date of Birth:	Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
EXAMINATION				
Height:	Weight:	BMI:	BP: /	Pulse:
		Vision: R 20/		L 20/ Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyper		
Eyes/Ears/Nose/Throat • Pupils Equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder/arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • Duck-walk, single leg hop		

- CLEARED for all sports WITHOUT restriction.**
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- NOT CLEARED:** Pending further evaluation For any sports For certain sport _____
- REASON:** _____
- Recommendations _____

(Student's name) _____ was examined by me on (date) / / for a pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete and parents/guardians.

Print Physician's Name: _____ Phone Number: _____

Physician's Signature: **X** _____ Physician's Office Stamp HERE →

