PARTICIPATION PHYSICAL EXAMINATION FORM – PHYSICIAN'S FORM

This form must be completed (all areas), signed by a physician, stamped with agency/office stamp and returned to the School Nurse before athletic/spirit group clearance can be issued.

LAST NAME: _____ FIRST NAME: _____ Date of Birth: _____

Sports:_____ GRADE: _____

ALLERGIES: _____ MEDICATIONS: _____

CIRCLE ANY OF THE FOLLOWING THAT APPLY: DIABETES SEIZURES ASTHMA HEART CONDITION

DATE OF PHYSICAL EXAMINATION: _____ Height: _____ Weight: _____ Pulse: _____ BP: _____

Hearing: ☐ Passed Right/Left <25 dB's all frequencies Vision: R 20/___ L 20/___ Both 20/___ Corrected?: Y N
☐ Failed_____ ☐ Not Done

MEDICAL	NORMAL	ABNORMAL FINDINGS
General Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)+		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back (including scoliosis screen)		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

+Having a third party present is recommended for the genitourinary examination.

Assessment: _____

☐ Cleared for all sports without restrictions.
☐ Not cleared – Reason _____
☐ Deferred – Requires further evaluation – Reason: _____

Agency/Office stamp here

Name of physician (print) _____ Address: _____ Telephone:_____

Signature of Physician _____M.D. or D.O. Today's date: _____
(Must be a licensed medical doctor)