Student Name _____

Circle the sport(s) you will be participating in:

Baseball	Basketball	Cheerleading	Cross Country	Field Hockey
Football	Golf	Soccer	Softball	Swimming
Track/Field	Tennis	Volleyball	Water Polo	Wrestling

Physical Examination

(To be completed by Medical Personnel)

Height _____

Weight _____

Blood Pressure _____
(sitting, left arm)

Pulse _____

Vision (optional)
Left eye 20 / _____
Right eye 20 / _____
Both eyes 20 / _____

with / without glasses

1. Skin	
2. Head	
3. Eyes (PERLA, EOMI, Fundi)	
4. Ears nose, throat	
5. Neck	
6. Lymphatic	
7. Respiratory	
8. Cardiovascular Heart (murmurs)?	
9. Abdomen	
10. Extremities	
11. Neurological Reflexes	
12. Orthopedic	
Cervical spine/back	
Arms/elbows/wrist/hands	
Hips	
Knees	
Ankles/feet	

√ = within normal limits **+ = see comments** **X= omitted**

Comments / Recommendations:

Student Name _____

MEDICAL CLEARANCE

(As appropriate for age and development)

[ ] Full contact/collision level (full, unrestricted participation)

[ ] Limited contact / impact

[ ] Non-contact: strenuous

[ ] Non-contact: non-strenuous

[ ] Clearance deferred or no participation at this time because: [ ]

Needs clearance by specialist

[ ] Orthopedist [ ] Cardiologist

Other:_____

[ ] Needs to complete rehabilitation for current condition(s) prior to participation

Physician's Statement:

(Student's name) _____ was examined by me on _____ and found physically fit to engage in high school athletics. Results are to encourage, but in no way guarantee the fitness and safety of this athlete.

Practitioner signature: _____ Date: _____

M.D. / D.O. / N.P. / P.A. / D.C.

Do not sign without student's name filled in

Physician's Office Stamp HERE (REQUIRED)