MARYVALE
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Educating Young Women for Life

Maryvale Preparatory School Physical Form

(This form is to be filled out by a medical professional)

Student Name: _____ **Date of Birth**:_____**Grade**:____**Date of Exam**: _____

HEALTH CONDITIONS AND ALLERGIES: Please list any health conditions and/or allergies.

Condition/Allergy 1: _____

Condition /Allergy 2: _____

Condition/Allergy 3: _____

MEDICAL HISTORY / SURGERIES: _____

MEDICATIONS: Please list all prescription, over-the-counter medicines, and supplements currently taking at home or at school. Include dosage, frequency, and time taken.

Medication 1: _____ Medication 2: _____

Medication 3: _____ Medication 4: _____

EpiPen/ Auvi-Q? : Yes / No **Self -Carry ?:** Yes / No **Trained to use EpiPen/ Auvi-Q? :** Yes / No ***Attach Allergy Action Plan**

Inhaler? : Yes / No **Self Carry?** Yes / No

EXAMINATION		
Height Weight		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
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 physical activity/sports without restriction for this school year.**

☐ **Not cleared.**

☐ **Pending further evaluation** _____

Reason: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to participate in the outline 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 student 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 student (and parents-guardians).

Medical Provider Name (Please Print/Stamp)_____**Phone** _____

Medical Provider's Signature _____ **Date:** _____