PHYSICAL EXAMINATION (to be completed by licensed physician, licensed chiropractic physician, licensed osteopathic physician, licensed physician assistant or certified advanced nurse practitioner).
Student Name (please print)

_____

List all sport(s) in which child/ward will participate.

_____

Height _____ Weight _____ % Body Fat (optional) _____ Resting Pulse _____ Blood Pressure _____

Temperature _____ Hearing – Right P _____ F _____ Left P _____ F _____

Visual Acuity - Right: 20/_____ Left: 20/ _____ Corrected YES NO Pupils Equal_____ Unequal _____

MEDICAL FINDINGS	NORMAL	ABNORMAL FINDINGS
General Appearance	_____	_____
Eyes/Ears/Nose/Throat	_____	_____
Lymph Nodes	_____	_____
Heart	_____	_____
Pulses	_____	_____
Lungs	_____	_____
Abdomen	_____	_____
Genitalia (males only)	_____	_____
Skin	_____	_____
Musculoskeletal		
Neck	_____	_____
Back	_____	_____
Shoulder, Arm	_____	_____
Elbow, Forearm	_____	_____
Wrist, Hand	_____	_____
Hip, Thigh	_____	_____
Knee	_____	_____
Leg, Ankle	_____	_____
Foot	_____	_____

ASSESSMENT OF EXAMINING PHYSICIAN ASSESSMENT

_____Cleared without limitation

_____Disability _____Diagnosis _____

_____

_____ Precautions _____

_____

_____ Disability _____ Diagnosis _____

_____

_____ Not cleared for _____ Reason _____

Recommendations _____

_____

Physician Signature _____ Date _____

Physician office stamp must be on this page.

75 F009 1/15/10 Submitted by District Athletic Director