PROVIDENCE CHRISTIAN SCHOOL OF TEXAS
ATHLETIC PHYSICAL EXAMINATION

Please Print Legibly

Student's Name:____Grade:____Date of Birth: ____________________

What sport(s) are you playing? (1)_______________________________________(2)_____________________(3) _______________________

Physical Examination: Participation Physical Evaluation: Must be completed before a student participates in games/meets/competitions. Must be completed by 1st practice.

Height:____________Weight:_______________Pulse:__________________BP:__/__________________(__/__________,__________________/__) Vision: R 20 /__________________L 20 /___________ Corrected: ☐Yes ☐No Contact Lenses___Glasses___Pupils: Equal__Unequal _____________

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance (i.e. Marfan Syndrome)		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart-Auscultation of the heart supine		
Heart-Auscultation of the heart standing		
Heart-Lower extremity pulses		
Heart-Upper extremity pulses		
Lungs		
Abdomen		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		
Neuro-muscular		
Spinal Screening ☐ Pass ☐Fail		

Comments regarding Abnormal Findings: ____

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PARTICIPATION RECOMMENDATIONS – CLEARED: ☐**Yes** ☐**No**

Cleared after completing evaluation and/or rehabilitation for: ____

List any activity this student should be excluded from: ____

Not cleared for:____**Reason:** ____

Recommendations: ____

Note to the Physician: **DO NOT SIGN if student fails.**

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Licensed Nurse Practitioner. Chiropractic examinations will not be accepted.

Name of Physician (print/type):____Date of Exam: ____________________

Physician's Phone Number(s): ____

Physician's Address: ____

Physician's Signature: ____