RETURN THIS FORM TO THE SCHOOL
ATHLETE PHYSICAL EXAMINATION FORM
PHYSICIAN'S FINDINGS/ASSESSMENT

Fill out this section before going to the doctor.

Name:_____ **Date of Birth:** _____ **Student ID #:** _____
Sport(s): _____ **School: Amador Valley High School** **Grade:** _____
Emergency Contact: _____ **Cell Phone:** _____ **Home Phone:**_____
Allergies: _____ **Medications:**_____

Date of Exam:_____ Height:_____ Weight:_____ Pulse:_____ BP:____/____

Hearing: ☐ Passed Right/Left ≤25dcbls (all frequencies) Vision: R 20/___ L 20/___ Both 20/___ Corrected: Y/N
☐ Failed_____ ☐ Not Done U/A: ☐ normal_____

Required Immunizations: Measles, Mumps, Rubella, Hepatitis B, Polio

☐Received Varicella Vaccine/or Varicella illness after 1 yr. of age Date of Last Tdap_____

☐Up to date (see attached Vaccine Documentation) ☐Not up to Date. Vaccines needed:_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
General Appearance		
Head/eyes/ears/nose/throat		
Neck		
Respiratory		
Heart		
Pulses		
Abdomen		
Skin		
Neuro		
Lymph Nodes		
Genitourinary (males only)		

MUSCULOSKELETAL

Back(+scoliosis screen)		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

Dr. Office Stamp Required In Box Below

Assessment/Plan:_____
☐Cleared for all sports without restrictions
☐Not cleared for ☐All Sports ☐Certain Sports_____Reason:_____
☐Deferred requires further evaluation (See Recommendations Below):
☐Cleared with restrictions (See Recommendations Below):
Recommendations:_____

Name of Physician (print)_____Address_____Phone_____

Signature of Physician:_____, M.D. or D.O. Date_____

I grant permission to release the information above to School Personnel

Parent/Guardian Signature:_____