

**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 \_\_\_\_\_

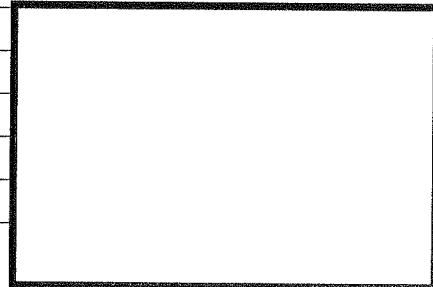
Up to date (see attached Vaccine Documentation)  Not up to Date. Vaccines needed: \_\_\_\_\_

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: \_\_\_\_\_