# PARTICIPATION PHYSICAL EXAMINATION FORM

This form must be completed (all areas), signed by an MD, NP, PA, or DO and include an agency/office stamp. Return the completed form to the School Nurse or Athletic Secretary for athletic/spirit group clearance.

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____

GRADE: _____ SPORTS: _____

ALLERGIES: _____ MEDICATIONS: _____

**CIRCLE ANY OF THE FOLLOWING THAT APPLY**: DIABETES SEIZURES ASTHMA HEART CONDITION

**DATE OF PHYSICAL EXAMINATION**: _____ Height: _____ Weight: _____Pulse:_____ BP:_____

Hearing: ____ Passed Right/Left <25 dB's all frequencies Vision: R 20/___ L 20/___ Both 20/___ Corrected: Y N
____ Failed _____ Not Done

| MEDICAL | NORMAL | ABNORMAL FINDINGS |
|---|---|---|
| General Appearance | | |
| Eyes/ears/nose/throat | | |
| Hearing | | |
| Lymph nodes | | |
| Heart | | |
| Murmurs | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)+ | | |
| Skin | | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | | |
| Back (including scoliosis screen) | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |

+Having a third party present is recommended for the genitourinary examination.

Assessment: _____

☐ **CLEARED FOR ALL SPORTS WITHOUT RESTRICTIONS**
☐ **NOT CLEARED – REASON _____**
☐ **Deferred – Requires further evaluation – Reason: _____**

Agency/office stamp required here

Name of MD/NP/PA/DO (print): _____ Address: _____ Telephone#: _____

Signature: _____, MD/NP/PA/DO Today's date: _____

Rev: 09/22