Physical Examination Form for Preparticipation **for West High School Sports**

This sports physical is good for one year from the date it was completed. *T*

Student's Name: _____ DOB: _____

Height: _____ Weight: _____ %BMI (optional): _____ Pulse: _____ BP: _____/ _____, (_____/_____, _____/_____)

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal Unequal

EMERGENCY INFORMATION

Allergies: _____

Other Information: _____

MEDICAL	Normal	Abnormal Findings
Appearance ● Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat ● Pupils equal ● Hearing		
Lymph Nodes		
Heart [1] ● Murmurs (auscultation standing, supine, +/- Valsalva) ● Location of point of maximal impulse (PMI)		
Pulses ● Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) [2]		
Skin ● HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [3]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional ● Duck-walk, single leg hop		

[1] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

[2] Consider GU exam if in private setting. Having third party present is recommended.

[3] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Clearance

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____

☐ Not cleared:

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports: _____

Reason/Recommendations: _____

I have evaluated the above named student and completed the preparticipation physical evaluation. The athlete does not present apparent contraindications to practice, tryout, and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician/ Provider: (print/ type/ stamp) _____ (MD, DO, NP, or PA) Date: _____

Address: _____ Phone: _____

Signature of Physician/ Provider: _____