

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: _____