

# Annual Physical Exam & Clearance for Physical Activity Form

To be completed and signed by a healthcare professional.



Santa Fe Indian School P.O. Box 5430 Santa Fe, NM 87505 | Telephone: (505) 989-6370 | Fax (505) 989-6338 | www.sfindianschool.org

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ F  M   
Last Name, First Name, MI

List past and current medical conditions:

Have you ever had surgery? If yes, please list all past surgical procedures.

Medicines and supplements: List all current prescriptions, over-the counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (i.e., medicines, pollens, food, stinging insects).

## EXAMINATION

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ ) Pulse: \_\_\_\_\_ Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected:  Y  N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart <sup>a</sup> • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) <small><sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history of examination findings, or a combination of those.</small>		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

Medically eligible for physical activities, including sports, without restriction

Medically eligible for physical activities with recommendations

Not medically eligible for physical activities

Recommendations:

**I have examined the student named on this form and completed the preparticipation physical examination.**

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of healthcare professional: \_\_\_\_\_ MD, DO, NP, or PA