



**Texas Association of Private and Parochial Schools
PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION**



STUDENT'S NAME _____ SPORT(S) _____

GENDER: _____ AGE: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ % OF BODY FAT: _____

PULSE: _____ BLOOD PRESSURE: ____/____ (____/____/____)

VISION R 20/____ L 20/____ CORRECTED: Y N Pupils: EQUAL _____ UNEQUAL _____

In keeping with the requirements of the Texas Association of Private and Parochial School, as a minimum requirement, this **PHYSICAL EXAMINATION FORM** must be completed prior to high school athletic participation each year of high school.

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart - Auscultation of the heart in the standing position			
Heart - Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

<p>CLEARANCE</p> <p><input type="checkbox"/> Cleared</p> <p><input type="checkbox"/> Cleared after completing evaluation/rehabilitation for: _____</p> <p><input type="checkbox"/> Not cleared for: _____ Reason: _____</p> <p>Recommendations: _____</p> <p>_____</p>

Provider Name: _____ Date of Examination: _____

Provider Signature: _____

Provider Address: _____

Provider Phone Number: _____

Required for:

- **New Students**
- **Student Athletes (including cheerleaders, dance team and mascot)**
- **Returning Students in grades 9 or 11**

This form is to be completed and signed by a physician.

In order to comply with the requirements of the State of Texas Department of Health, it is necessary that immunization records be completed and be on file prior to the first day of class at Shelton School. Your child will not be admitted without an immunization record on file.

Name _____ Date of Birth _____ Grade _____

Home Address _____

Allergies _____

Medical Conditions _____

	Medication	DOSE	Time(s)	Date Prescribed	DATE DISCONTINUED
Medications					

Attach a copy of student's immunization record.