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

CLEARANCE

☐ Cleared
☐ Cleared after completing evaluation/rehabilitation for: _____
☐ Not cleared for: _____ Reason: _____
Recommendations: _____
_____

Provider Name: _____ Date of Examination: _____
Provider Signature: _____
Provider Address: _____
Provider Phone Number: _____

SHELTON STUDENT HEALTH INFORMATION
17301 Preston Rd • Dallas, TX 75252 • 972-774-1772 Option 6 • FAX 972-408-4139 • Nurse Email: nurses@shelton.org

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 _____

Medications

Medication	DOSAGE	Time(s)	Date Prescribed	DATE DISCONTINUED

Attach a copy of student's immunization record.