

## PARTICIPATION PHYSICAL EXAMINATION FORM – PHYSICIAN’S FORM

This form must be completed (all areas), signed by a physician, stamped with agency/office stamp and returned to the School Nurse before athletic/spirit group clearance can be issued.

LAST NAME: _____	FIRST NAME: _____	Date of Birth: _____
Sports: _____	GRADE: _____	
ALLERGIES: _____	MEDICATIONS: _____	
<b>CIRCLE ANY OF THE FOLLOWING THAT APPLY:</b> 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 here

Name of physician (print) \_\_\_\_\_ Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Signature of Physician \_\_\_\_\_ M.D. or D.O.      Today's date: \_\_\_\_\_  
 (Must be a licensed medical doctor)