

PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

Name of Athlete Examined: _____ Date of Exam: _____ / _____ / _____

Height: _____ Weight: _____ Pulse: _____ BP: _____ / _____ Vision: **R** 20/ _____ **L** 20/ _____

Clinical Examination: Check each item in appropriate column. Elaborate as needed for clarity of findings.

Normal	Abnormal	
_____	_____	H.E.E.N.T _____
_____	_____	Skin _____
_____	_____	Cardiovascular HR: _____
_____	_____	Lungs _____
_____	_____	Abdomen _____
_____	_____	Hernia and Genitalia (males) _____
_____	_____	Neurological _____
_____	_____	Spinal Column (scoliosis, etc) _____
_____	_____	Upper Extremities _____
_____	_____	Lower Extremities _____

COMMENTS AND RECOMMENDATIONS

I have examined this individual on this date and find him/her medically able to participate in interscholastic athletics.

_____ CLEARED FOR FULL ATHLETIC PARTICIPATION, WITHOUT RESTRICTIONS

_____ CLEARED FOR ATHLETIC PARTICIPATION, WITH RESTRICTIONS (detail restrictions here) _____

_____ DEFERRED CLEARANCE UNTIL: rehab _____ recheck _____ consultation _____ lab _____ other: _____

_____ DENIED CLEARANCE FOR ATHLETIC PARTICIPATION (detail reasons here) _____

_____ PHYSICIAN SIGNATURE _____ DATE _____

_____ PHYSICIAN ADDRESS _____ PHONE NUMBER _____