PHYSICAL EXAMINATION

(Physical examination is required each school year after May 30 of the preceding school year and is good for one year through May 30 of the next year) **

NAME: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____ AGE: _____ DOB: _____

*Tanner stage or Maturation index: (males only): _____ BP: _____

Percent Body Fat: _____ Pulse: _____

*(Exercise) _____

Audiogram: _____ *(Recovery) _____

*FEV or Peak Flow (rest) _____

*Vision: Corrected (L) _____ (R) _____ (Both) _____ *(Exercise) _____

Uncorrected (L) _____ R _____ (Both) _____ *(Recovery) _____

	N	ABNORMAL		N	ABNORMAL
Eyes			CervicalSpine/Neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/Elbow/Wrist/Hand		
Teeth			Knees/Hips		
Skin			Ankle/Feet		
Lymphatic			Marfan Screen		
Lungs			*Urina		
Heart			*Hemoglobin or HCT and/or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

*WHEN MEDICALLY INDICATED
(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)
^WITH SPECIAL INDICATIONS
(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

I have reviewed the data above, reviewed his/her medical history form
and make the following recommendations for his/her participation in athletics.

__ CLEARED WITHOUT RESTRICTIONS
__ Cleared AFTER further evaluation or treatment for: _____
__ Cleared for LIMITED PARTICIPATION (check and explain "reason" for all that apply)
___ Not cleared for (specific sports)

____ Cleared only for (specific sports)
Reason(s): _____

___NOT CLEARED FOR PARTICIPATION:
Reason(s) _____

__Other Recommendations:
__ Recommend close monitoring during early conditioning because of weight/fitness/other
__ Recommend restrictions or monitoring of weight loss or gain
__ Other: _____

Reason(s): _____

Physician Signature: _____ M.D. Date of Examination:* _____

Date Signed: _____ *(MD,DO,LPN,PA)

Examiner's Name and degree (print): _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____