PHYSICAL EXAMINATION

PRE-PARTICIPATION PHYSICAL EVALUATION

Name ______ Date of Birth ______

Height ______ Weight ______ Pulse ______ Blood Pressure ____ / ____

Vision R 20/ ____ L 20/ ____ Corrected: Y N Pupils: Equal Unequal

Record date of most recent immunizations (shot) for DT/Td ______ Hep B ______ Varicella ______

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

☐ Cleared for all activities

☐ Not cleared for: ______

Reason: ______

Recommendations: ______

I HEREBY CERTIFY THAT I AM QUALIFIED BY TRAINING AND EXPERIENCE TO PROPERLY PERFORM THE EXAMINATION AND MAKE THE EVALUATION REFLECTED ON THIS FORM

Name of physician *(print / type)* ______ **Date** ______

Address ______ Phone ( ) ______

Signature of physician ______ **, MD, DO, DC or RPA**

(please circle)