

## PHYSICAL EXAMINATION RECORD

To be completed by a licensed professional.

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance exams.

NAME:	HEIGHT	WEIGHT	
PULSE	BLOOD PRESSURE	HEMOGLOBIN (optional)	UA (optional)
	NORMAL	ABNORMAL FINDINGS	INITIALS

1. EYES \_\_\_\_\_
  2. EARS, NOSE, & THROAT \_\_\_\_\_
  3. MOUTH AND TEETH \_\_\_\_\_
  4. NECK \_\_\_\_\_
  5. CADRIOVASCULAR \_\_\_\_\_
  6. CHEST & LUNG \_\_\_\_\_
  7. ABDOMEN \_\_\_\_\_
  8. SKIN \_\_\_\_\_
  9. GENITALS-HERNIA \_\_\_\_\_
  10. MUSCOLOSKELETAL: ROM, STRENGTH, ECT. \_\_\_\_\_
  11. NEUROLOGICAL \_\_\_\_\_
- COMMENTS RE ABNORMAL FINDINGS: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### Participation Recommendations:

- Full and unlimited participation
- Limited participation – **May not** participate in the following (checked):
- Baseball  Basketball  Cross Country  Football  Golf  Soccer  Softball  Swimming  Tennis  Track
- Volleyball  Wrestling

Clearance Pending Documented Follow up of:

\_\_\_\_\_

\_\_\_\_\_

No Athletic participation

\_\_\_\_\_  
Licenses Professionals Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone Number

### Parent/Guardian Permission & Release:

I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to give first aid treatment to this student at an athletic event in case of injury.

\_\_\_\_\_  
Typed or Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date