

PREPARTICIPATION PHYSICAL EVALUATION <> PHYSICAL EXAMINATION FORM

To be completed by a physician

NAME: _____ DATE OF BIRTH: ____ / ____ / ____

HEIGHT: ____ ft. ____ inches WEIGHT: _____ lbs. % BODY FAT (optional) _____ %

PULSE: _____ BP ____ / ____ (____ / ____, ____ / ____)

VISION: R 20 / _____ L 20 / _____ CORRECTED: Y N PUPILS: Equal ____ Unequal ____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes / Ears / Nose / Throat			
Hearing			
Lymph Nodes			
Heart			
Mumurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand / Fingers			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot / Toes			

NOTES: _____

NAME OF PHYSICIAN (print or type): _____

ADDRESS: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

MD or DO

PREPARTICIPATION PHYSICAL EVALUATION <> CLEARANCE FORM

NAME: _____ SEX: _____ AGE: _____

DATE OF BIRTH: ____/____/____

Cleared without restriction

Cleared, with recommendations for further evaluation or treatment for: _____

NOT CLEARED FOR:

All Sports

Certain Sports: _____

REASON: _____

RECOMMENDATIONS: _____

EMERGENCY INFORMATION:

Allergies: _____

Other Information: _____

Immunizations (e.g.: tetanus / diphtheria; measles; mumps; rubella; hepatitis A,B; influenza;
poliomyelitis; pneumococcal; meningococcal; varicella)

UP TO DATE (see attached documentation)

NOT UP TO DATE

Specify: _____

NAME OF PHYSICIAN (print or type): _____

ADDRESS: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

MD or DO