**PHYSICAL EXAMINATION FORM**

**Name**  
__________________________________________________________________________________

**Date of birth**
__________________________

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**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

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**EXAMINATION**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
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**BP**  

<table>
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<tr>
<th>Male</th>
<th>Female</th>
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**Pulse**

Vision R 20/  
L 20/  Corrected  

**MEDICAL**

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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**Appearance**
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)

**Eyes/ears/nose/throat**
- Pupils equal
- Hearing

**Lymph nodes**

**Heart**
- Murmurs (auscultation standing, supine, +/- Valsalva)
- Location of point of maximal impulse (PMI)

**Pulses**
- Simultaneous femoral and radial pulses

**Lungs**

**Abdomen**

**Genitourinary** (males only)

**Skin**
- HSV, lesions suggestive of MRSA, tinea corporis

**Neurologic**

**MUSCULOSKELETAL**

<table>
<thead>
<tr>
<th>Neck</th>
<th>Back</th>
<th>Shoulder/arm</th>
<th>Elbow/forearm</th>
<th>Wrist/hand/fingers</th>
<th>Hip/thigh</th>
<th>Knee</th>
<th>Leg/ankle</th>
<th>Foot/toes</th>
<th>Functional</th>
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- Duck-walk, single leg hop

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☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for  
____________________________________________________________________________________________________________________________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports  
____________________________________________________________________________________________________________________________________________

**Reason**
___________________________________________________________________________________________________________________________

**Recommendations**
________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________

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I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

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Name of physician (print/type)  
___________________________________________________________________________________________________________

Date  
__________________________

Address  
___________________________________________________________________________________________________________

Phone  
__________________________

Signature of physician  
___________________________________________________________________________________________________________,

MD or DO

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