

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)