

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____ (____ / ____, ____ / ____)

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

| | NORMAL | ABNORMAL FINDINGS | INITIALS* |
|-----------------------------|--------|-------------------|-----------|
| MEDICAL | | | |
| Appearance | | | |
| Eyes/ears/nose/throat | | | |
| Hearing | | | |
| Lymph nodes | | | |
| Heart | | | |
| Murmurs | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary (males only)+ | | | |
| Skin | | | |
| MUSCULOSKELETAL | | | |
| Neck | | | |
| Back | | | |
| Shoulder/arm | | | |
| Elbow/forearm | | | |
| Wrist/hand/fingers | | | |
| Hip/thigh | | | |
| Knee | | | |
| Leg/ankle | | | |
| Foot/toes | | | |

*Multiple-examiner set-up only.

+Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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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 _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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PARENTAL CONSENT

I HEREBY GIVE MY CONSENT FOR THE ABOVE NAMED STUDENT TO REPRESENT St. Pius X High School in athletic activities. I also give my consent for my student to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I fully understand that the school will provide transportation when it is possible. If this is not possible, he/she may only transport themselves or be transported by an authorized adult. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school responsible for any injury occurring to the above named student in the course of such athletic activities or such travel.

 SIGNATURE OF PARENT OR GUARDIAN _____

DATE _____

 Please attach Georgia Certificate of Immunization Form 3231 (New Students Only)