CLEARANCE FORM (TO BE SIGNED BY PHYSICIAN AND RETURNED TO ATHLETICS OFFICE

Physical Examination – ***Please Print***

Student's Name: _____
Last First Middle

Address: _____
Street City Zip

Birth Date: _____ M / F Graduating Year_____ HS Attended Last Year: _____

Parent/Guardian Name: _____ Cell #:_____

Email Address: _____

To Be Completed by Physician:

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

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

MEDICAL:	**Normal**	**Abnormal Findings**	**Initials**
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL:	**Normal**	**Abnormal Findings**	**Initials**
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Station-based examination only

CLEARANCE:

____ Cleared

____ Not Cleared for:_____ Reason: _____

____ Cleared after completing Evaluation/Rehabilitation for:_____

Evaluation/Rehabilitation Completed: _____
Physician's Signature Date

Final Clearance: _____
Original Examining Physician's Signature Date

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities. (Note exception above)

_____ **Phone #:** _____

_____

_____ _____

Physician's Name, Address (stamp or print) **Examiner's Signature DATE**

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

Revised: 4/26/19