

Name			Date of Birth	
Height	Weight	Pulse		BP
Vision: Right: 20/	Left: 20/	Corrected: Yes	No	Pupils: Equal <input type="checkbox"/> Unequal <input type="checkbox"/>

Allergies: _____

Other Health Concerns: _____

PHYSICAL EXAMINATION

MEDICAL	Normal	Abnormal Findings	Initials
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			

Notes: _____

CLEARANCE

- Cleared without restriction to participate in athletics.
 - Cleared with recommendations for further evaluation or treatment for: _____
 - Not cleared for: _____ Reason: _____
- Recommendations: _____

Name of Physician/Nurse Practitioner (print): _____

Address _____ Phone: _____

Signature of Physician/Nurse Practitioner: _____ Date: _____

**Primary care physicians, please include a copy or verification that this student's immunizations are complete and up to date.