



STUDENT NAME _____

SEX _____

PHONE _____

D.O.B. _____

AGE _____

THIS PORTION TO BE COMPLETED BY EXAMINING MEDICAL PRACTITIONER

Ht: _____ Wt: _____ B/P: R _____ L _____ Pulse: _____ Eyes: R _____ L _____

Examination	Normal	Abnormal	Orthopedic	Normal	Abnormal
HEENT			Spine		
Neck			Extremities		
Lungs			Nervous		
Heart: Supine			Shoulder		
Heart: Standing or with Valsalva Maneuver			Pelvic Height		
Abdomen			Knee Laxity		
Hernia (males only)			Right	ACL	
Skin				PCL	
Other:				MCL	
				LCL	
			Left	ACL	
				PCL	
				MCL	
				LCL	
			Other:		

Therapist/Clinician: _____

Refer to Physician: _____ Athletic Trainer: _____

A CURRENT – YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR.

Physician's Statement

- 1. CLEARED WITHOUT RESTRICTIONS.
- 2. Cleared for **LIMITED PARTICIPATION** (specify): _____
- 3. **NOT CLEARED** for participation (explanation): _____
- 4. Requires further evaluation before final recommendation. _____

I certify that I have examined the above student-athlete and recommend him/her as being able to compete in supervised athletic activity as dictated by the clearance recommendations above.

Printed Name: _____

Date: _____

Signature: _____ MD, DO, PA, or NP