

Athletic Physical

To Be Completed By Physician's Office

Date: _____

Patient Name: _____ DOB: _____ Age: _____ Sex: M F

Physician Name: _____ Physician Phone: _____

HISTORY

C O M P L E T E	L I M I T E D	Height _____	Weight _____	BP ____/____	Pulse _____	
		Vision R20/____	L20/____	Corrected: Y N	Pupils _____	
		Normal	Abnormal Findings			Initials
	Cardiopulmonary					
	Pulses					
	Heart					
	Lungs					
	Tanner Stage	1	2	3	4	5
	Skin					
	Abdominal					
	Genitals					
	Musculoskeletal					
	Neck					
	Shoulder					
	Elbow					
	Wrist					
	Hand					
	Back					
	Knee					
	Ankle					
Foot						
Other						

Clearance

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: _____
- C. Not cleared for:
 - Collision
 - Contact
 - Non-contact: Strenuous Moderately strenuous Non-strenuous

Recommendation: _____

Name of Physician/PA or Nurse Practitioner _____

Address _____ Phone _____

I hereby certify that I have examined _____ and that the student was found physically fit to engage in school sports.

Signature of MD/DO, PA, NP _____ Date _____