Signature of Parent/Guardian_

| School: Grade in School Sport(s) expected to play | Student Name: | | | Sex | : | Aae | Date of Birth | 1 | 1 |
|--|---|--------------|----------|-------------------|----------|----------------------|---------------------------------|----------|---|
| Arme of Parent/Guardian: Person to Contact in Case of Emergency: Relationship to Student: Personal/Family Physician: City/State: Office Phone: () Part 2. Medical History (to be completed by parent), Explain "yes" answers below. Circle questions for which you do not know the answer responsible to the part of th | | | | | | | | | |
| Person to Contact in Case of Emergency: Relationship to Student: Home Phone: () | | | | | | | | | |
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| Relationship to Student: Home Phone: () Work Phone: () Personal/Family Physician: City/State: Office Phone: () Personal/Family Physician: City/State: City/ | | | | | | | | | |
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| Hepatitus BChickenpox: Does child have frequent or severe headaches? Has child ever had numbness or tingling in his/her arms, hands, legs, or feet? Has child ever had a stinger, burner, or pinched nerve? | . Has child ever been knocked out, become unconscious, or lost his/h | er | | | | | , , | | |
| Does child have frequent or severe headaches? | • | | _ | Hepatitus B_ | | Chic | kenpox: | | |
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| Has child ever had a stinger, burner, or pinched nerve? | | 5, | | | | | | | |
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| piain Yes answers nere: | xplain "Yes" answers here: | | | | | | | | |
| | | | | | | | | | |

Date:_



Athletic Pre-participation Physical Evaluation (Page 2 of 2)

This completed form must be kept on file by the school

| Part 3. Physical Examination (t | to be completed by phys | ician). | | | |
|------------------------------------|-----------------------------|--------------------|------------------------------|--|--------------------------------|
| Student Name: | | | | Date of Birth | <i>!</i> |
| Height: Weight: _ | % Body Fat (| optional): | Pulse: Blo | od Pressure:/ (/ | ,) |
| Visual Acuity: Right 20/ Le | ft 20/ Corrected: | Yes No | Pupils: Equal | Unequal | |
| FINDINGS | NORMAL | ABNORM | AL FINDINGS | 1 | NITIALS* |
| MEDICAL | | | | | |
| 1. Appearance | | | | | |
| 2. Eyes/Ears/Nose/Throat | | | | | |
| Lymph Nodes | | | | | |
| 4. Heart | | | | | |
| 5. Pulses | | | | | |
| 6. Lungs | | | | | |
| 7. Abdomen | | | | | |
| 8. Skin | | | | | |
| MUSCULOSKELETAL | | | | | |
| 9. Neck | | | | | |
| 10. Back | | | | | |
| 11. Shoulder/Arm | | | | | |
| 12. Elbow/Forearm | | | | | |
| 13. Wrist/Hand | | | | | |
| 14. Hip/Thigh | | | | | |
| 15. Knee | | | | | |
| 16. Leg/Ankle | | | | | |
| 17. Foot | | | | | |
| * - Station-based examination on | ly | | | | |
| ASSESSMENT OF EXAMINING | PHYSICIAN | | | | |
| Cleared without limitation | | | | | |
| Not cleared for | | | | Reason | |
| Cleared after completing e | valuation/rehabilitation fo | r: | | | |
| Referred to | | | | For | |
| | | | | | |
| Recommendations: | | | | | |
| | | | | | |
| | · | | | | Date: |
| Address: | | | | | MD DO DO ADNO |
| Signature of Physician: | | | | | , MD, DO, DC, ARNP |
| ASSESSMENT OF PHYSICIAN | | | harman affirm and individual | landa and the state of the stat | all and a management of the Co |
| , | ion(s) for which referred v | /as/were periormed | by myself or an individual | under my direct supervision with the fo | bilowing conclusion(s) |
| Cleared without limitation | | | | Danasi | |
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| кесоптепаановз: | | | | | |
| Name of Physician (mint on the chi | | | | | Date: |
| | | | | | Date: |
| Address: | | | | | MD DO DO ARNE |

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.