

**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