Emery
SECONDARY SCHOOL

ATHLETIC PHYSICAL EXAMINATION FORM

The section below is to be completed by physician or staff after history and consent forms are completed.

Student Name: ________________________________ **Birth Date:** ________________

Height: ____________ **Weight:** _____________ **% Body Fat** *(optional)*: _________

Pulse: _____________ **Blood Pressure:** ____________

Vision: R 20/____ L 20/ _____ **Corrected?** Yes No **Pupils equal?** Yes No

MEDICAL	Normal	Abnormal findings	Initials
Appearance			
Eyes/Ears/Throat			
Hearing			
Lymph nodes			
Heart			
Mumurs			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Legs/Ankles			
Feet/Toes			

Notes regarding physical exam: ____

Known allergies: ______________________________

General Wellness:
(Please note pertinent responses below.)

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, or dip/snuff.
6. During the past 30 days, have you had at least 1 drink of alcohol?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any supplements to help you gain or lose weight or improve your performance?

Notes: ______________________________

PERMISSIONS AND CLEARANCES

In regard to athletic participation, this student is:

- ❑ **Cleared without restriction**
- ❑ **Cleared, with recommendations for further evaluation or treatment for:** ______________________________

- ❑ **Not cleared for:** ❑ **All Sports** ❑ **Specified Sports**: ______________________________

Reasons/Recommendations: ______________________________

Name of Examiner (*Please print or type*): ______________________________

(If the Physician's Assistant or Advanced Nurse Practitioner performed the exam, please include the name and address of collaborating physician or physician's group.)

Address: ______________________________ **Phone:** ______________

Signature of Examiner: ______________________________ **Date:** ______________