

STUDENT'S NAME (Please Print)

Date of Birth

PHYSICAL EXAMINATION

Middle School Sports Program

To be completed by medical personnel *

Height: _____ Weight: _____ BP: _____ / _____ Pulse: _____

Vision (optional) Left eye: 20/ _____ Right eye: 20/ _____

KEY: ✓ = WNL X = Item omitted + = see "Notes" below

1.	Skin	
2.	Head	
3.	Eyes (PERL, EOMI, Fundi)	
4.	Ear, Nose, Throat	
5.	Neck	
6.	Lymphatic	
7.	Cardiovascular	
8.	Heart (murmurs?)	
9.	Abdomen	
10.	Genitalia (including hernia)	

11.	Extremities	
12.	Neurological	
13.	Orthopedic	
	Cervical spine/back	
	Arms / elbows / wrists / hands	
	Hips	
	Knees	
	Ankles / feet	
14.	Developmental	
	Tanner staging (1-5)	

Please initial or check one of the two clearance options below:

1. _____ Full, unrestricted clearance

or

2. _____ Not cleared. Needs clearance by specialist(s) as indicated below and in Notes.

_____Orthopedist _____Cardiologist _____Other:

Notes:

Effective **May 4, 2011**, screenings may only be performed by a licensed **MD, DO, PAC, or NP**.

** Screening must be performed **AFTER May 25, 2021 for 2021-2022** school year participation.

Athletic Screening Performed By:

Screener's Office Stamp

Print Name/Title (M.D. / D.O. / P.A.C. / N.P.)

Signature

Date Signed

