





# PRE-PARTICIPATION PHYSICAL EVALUATION for INTERSCHOLASTIC ATHLETICS

This page to be completed by physician/nurse practitioner/physician assistant

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ % BODY FAT (optional) \_\_\_\_\_ PULSE: \_\_\_\_\_ BP: \_\_\_\_\_  
VISION: R 20/\_\_\_\_ L 20/\_\_\_\_ CORRECTED? Y\_\_ N\_\_ PUPILS: EQUAL \_\_\_\_\_ UNEQUAL \_\_\_\_\_

	NORMAL	ABNORMAL FINDING	INITIALS *
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*Station-based examination only

### CLEARANCE:

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
\_\_\_\_\_
- NOT cleared for [Sport(s)]: \_\_\_\_\_ Reason: \_\_\_\_\_  
Recommendation: \_\_\_\_\_

Name of Physician/Nurse Practitioner/Physician's Assistant \_\_\_\_\_ Date: \_\_\_\_\_  
Print or Type

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician/Nurse Practitioner/Physician Assistant \_\_\_\_\_

**Date of Exam:** \_\_\_\_\_

**PHYSICIANS STAMP:**