



## Pre-Participation Physical Examination

This form is to be completed by the examining health care provider

Name _____	Date of Birth _____
Height _____	Weight _____
Pulse _____	BP _____/_____
Vision R: 20/____	L: 20/____
Corrected: Y N (Contacts / Glasses)	Pupils: Equal Unequal

	Normal	Abnormal Findings	Initials
<b>Medical</b>			
Appearance / skin			
E/E/N/T			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Neurological			
<b>Musculoskeletal</b>			
Head / Neck			
Back			
Upper Extremity			
Lower Extremity			
<b>Functional</b>			
ROM / Flexibility			

I today conducted a pre-participation examination of the above named athlete. Based on my findings, the athlete is:

Cleared – all sports     
  Cleared – non-collision sports only     
  Cleared – non-contact sports only  
 Cleared after completing evaluation / rehabilitation for: \_\_\_\_\_  
 Not cleared for (Reason /Recommendations): \_\_\_\_\_

Name of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_  
 (please print)

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature of Physician \_\_\_\_\_, MD DO ARNP PA-C