

**Pre-Participation Physical Evaluation
PHYSICAL EXAMINATION**

Date of examination: _____
 Name: _____ Date of Birth: _____
 Height: _____ Weight: _____ Pulse: _____ BP: _____
 Vision: R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

*Certified Wrestling Minimum Weight: _____
 90% OF ABOVE WEIGHT*

Physician's Signature: _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
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			

CLEARANCE:

I have on this date, personally examined this pupil, reviewed the history and other data recorded on both sides of this form. I find this student physically able to compete in the interscholastic sports listed below which are NOT crossed out.

Basketball Cheerleading Field Hockey Football Golf Lacrosse Soccer
 Baseball Softball Tennis Track & Field Volleyball Wrestling Cross Country

(circle) Yes No

Not cleared for: _____ Reason: _____

Recommendations:

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____ MD or DO

TO BE SIGNED BY PARENT ON BOTH SIDES AFTER THE PHYSICAL IS COMPLETED:

I have on this date reviewed the data recorded on both sides of this form.

Signature of parent: _____ Date: _____