# PHYSICAL EXAMINATION FORM

**Name:** ___________________________  **Grade:** __________  **Date of Birth:** ______________

## EXAMINATION

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>Vision:</th>
<th>R 20/</th>
<th>L 20/</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP: / ( / )</td>
<td>Pulse:</td>
<td>Corrected?</td>
<td>Y</td>
<td>N</td>
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</tbody>
</table>

## MEDICAL

### NORMAL

- **Appearance**
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)

- **Eyes, ears, nose, and throat**
  - Pupils equal
  - Hearing

- **Lymph nodes**

- **Heart**
  - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)

- **Lungs**

- **Abdomen**

- **Skin**
  - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis

### ABNORMAL FINDINGS

## MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Neck</th>
<th>Back</th>
<th>Shoulder and arm</th>
<th>Elbow and forearm</th>
<th>Wrist, hand, &amp; fingers</th>
<th>Hip and thigh</th>
<th>Knee</th>
<th>Leg and ankle</th>
<th>Foot and toes</th>
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### NORMAL

### ABNORMAL FINDINGS

- **Functional**
  - Double-leg squat test, single-leg squat test, step drop test

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I have examined the student named on this form and completed a physical evaluation. A copy of the physical examination findings is on record with my office and can be made available at the request of the parents. If conditions arise after an athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and/or parents or guardians.)

**Medically eligible for all sports without restriction:** YES NO

**Medically eligible for certain sports:**

________________________________________________________

**Recommendations:**

____________________________________________________________________

____________________________________________________________________

**Name of healthcare professional (print or type)__________________________**

**Address __________________________________________________________**

**Phone ___________________________**

**Address _______________________________________________**

**Date ___________________________**

**Signature of healthcare professional__________________________, MD, DO, NP, or PA**