HCPS

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 *
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
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_____

I hereby certify that I have reviewed the student pre-participation History Form and performed a comprehensive initial pre-participation physical evaluation of the herein named student within the previous 365 days of signature. On the basis of such evaluation and the review of a current History Form, I certify that the student is physically fit to participate in an interscholastic sports program for the current school year. **The date of the student pre-participation History Form and the date of the health care provider's signature below must be after June 7th.**

DATE OF EXAM:_____

PHYSICIANS STAMP: