

PROVIDER'S PHYSICAL EXAMINATION FORM

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

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hands/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple examiner set-up only.

Notes: _____

CLEARANCE

- Cleared without restriction
 Cleared with recommendations for further evaluation or treatment for: _____

Not cleared for All sports Certain sports _____ Reason: _____
 Recommendations: _____

Name of physician/medical provider [print or type] _____ Date _____
 Address _____ Phone _____
 Signature of physician/medical provider _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

Typed or printed name of parent or guardian _____ Signature of parent or guardian _____
 Date _____ Address _____ Insurance (Company name) _____
 Parent's Home Phone _____ Parent's Work Phone _____ Parent's Cell Phone _____ Additional Phone (if any-specify) _____

ALL INFORMATION IS TO REMAIN CONFIDENTIAL

(Revised 4/09)

VERIFICATION OF INSURANCE: *The School District DOES NOT provide medical insurance* benefits for students who choose to participate in sports programs. Medical insurance **MUST BE PROVIDED** in order for the student to participate. "North Western Scholastic Insurance" forms for coverage during sports are available in the Activities Office. **THE ATHLETE IS COVERED WITH THE FOLLOWING HEALTH INSURANCE:**

INSURANCE (Company Name) _____ **POLICY #** _____