

Martin County School District Pre-Participation Physical Evaluation

This completed form must be kept on file by the school. This form is valid for 365 calendar days from the date of the evaluation as written below.

Part 3. Physical Examination (to be completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Student's Name: _____ Date of Birth: ____/____/____

Height: _____ Weight: _____ % Body Fat (optional): _____ Pulse: _____ Blood Pressure: ____/____ (____/____, ____/____)

Visual Acuity: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
MUSCULOSKELETAL			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Arm	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____

• - station-based examination only

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

Cleared without limitation

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Referred to: _____

Recommendations: _____

Name of Physician/ Physician Assistant/ Nurse Practitioner (print or type): _____ Date: _____

Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (IF APPLICABLE)

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

Cleared without limitation

Cleared after completing evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Physician (print or type): _____ Date: _____

Address: _____

Signature of Physician: _____

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.