ST. EDMUND PREPARATORY HIGH SCHOOL

ANNUAL ATHLETIC PHYSICAL EVALUATION FORM

(To be completed by the examining physician)

Examination Date: _________________

-STUDENT INFORMATION-

Student's Name: ___________________________________ Sport: ____

Sex: M F (circle one) Age: ________ Grade: _____________ Date of Birth: ____

Address: ____

City/State/Zip:____ Home Phone: ____

Parent/Guardian's Full Name: ____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Height: _________ Weight: _________ Blood Pressure: ______/_______ Pulse: _____bpm.

Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

Indicators	Normal? (Circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (incl. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine: Range of Motion:	YES YES	NO NO	
Scoliosis:	YES	NO	
Upper Extremities:	YES	NO	
Lower Extremities:	YES	NO	
Neurological: Balance & Coordination: Romberg:	 YES YES	 NO NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (if yes/possible, please explain)	YES/ Possible	NO	

Most recent immunizations/Dates:
Medications currently being used:
Additional Observations:

General Diagnosis: ____
Recommendations: ____

CLEARANCES

A. Student MAY participate in the following sports: (CHECK ALL THAT APPLY)

___ CONTACT/COLLISION **___ NON-CONTACT/STRENUOUS**
___ LIMITED CONTACT **___ NON-CONTACT/NON-STRENUOUS**

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	**Limited Contact**	**Non-Contact**	
		Strenuous	**Non-strenuous**
Ice Hockey	Baseball	Boosters	Bowling
Soccer	Basketball	Dance	Golf
Wrestling	Cheerleading	Running/Cross Country	
	Handball	Strength Training	
	Skiing	Swimming	
	Softball	Tennis	
	Volleyball	Track	

B. Student MAY participate in following sport(s) ONLY AFTER completing evaluation/rehabilitation: (CHECK ALL THE APPLY)

___ CONTACT/COLLISION **___ NON-CONTACT/STRENUOUS**
___ LIMITED CONTACT **___ NON-CONTACT/NON-STRENUOUS**

Reasons for disqualification:

Physician's/Provider's Stamp:

EXAMINED BY:
Family Physician/Provider_____

____MD ____DO____NP____PA

Physician's/Provider's Signature: ____ **Date:** ______________________________

Address:____**City/State/Zip:**______________________________________

Phone:____**Fax:**____

FORM WILL NOT BE ACCEPTED UNLESS MECHANICALLY STAMPED

This certificate is void if the student is absent from school five (5) or more consecutive days because of illness or significant injury. A new certificate must be issued before student is allowed to participate.