



EPISCOPAL HIGH SCHOOL

PHYSICIAN PHYSICAL EXAMINATION

Please complete the medical history form prior to your physical exam, and bring the history form to your physician for review.

Student's Name (print): _____ Date of Birth _____ Sex ___ Age ___ Grade ___
 Height _____ Weight _____ Pulse _____ BP ___/___

Vision: R 20/___ L 20/___ Corrected: ___ Y ___ N
 ___Eyeglasses ___Contacts
 Pupils: ___Equal ___Unequal
 Hearing: Right Ear: ___Pass ___Fail Left Ear: ___Pass ___Fail

NORMAL

ABNORMAL FINDINGS

	NORMAL	ABNORMAL FINDINGS
MEDICAL		
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart-Auscultation of the heart in the supine position.		
Heart-Auscultation of the heart in the standing position.		
Heart-Lower extremity pulses		
Pulses		
Lungs		
Abdomen		
Genitalia (males only)		
Skin		
Marfan's Syndrome arachnodactyly pectus excavatum joint hypermobility scoliosis		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

CLEARANCE

___ Cleared
 ___ Cleared after completing evaluation/rehabilitation for: _____
 ___ Not cleared for: _____ Reason: _____
 Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) or physical activities as outlined above. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parents/guardians).

Name of Physician (print/type): _____ Date _____
 Address _____ Phone _____
 Signature of Physician _____, MD, DO, NP or PA

