



**MOUNT SI HIGH SCHOOL
PHYSICAL EXAMINATION**

TO BE COMPLETED BY PHYSICIAN

ATHLETE'S FULL NAME: _____

YEAR GRADUATING: _____

Height: _____ Weight: _____ % Body fat (optional): _____ Pulse: _____
BP: ____/____

Vision: R 20/____ L 20/____ Corrected? Y N Pupils: Equal ____ Unequal ____

Normal

- | | |
|--|--|
| <input type="checkbox"/> Appearance _____ | <input type="checkbox"/> Neck _____ |
| <input type="checkbox"/> Eyes/Ears/Nose/Throat _____ | <input type="checkbox"/> Back _____ |
| <input type="checkbox"/> Lymph Nodes _____ | <input type="checkbox"/> Shoulder/arm _____ |
| <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Elbow/forearm _____ |
| <input type="checkbox"/> Pulses _____ | <input type="checkbox"/> Wrist/hand _____ |
| <input type="checkbox"/> Lungs _____ | <input type="checkbox"/> Hip/Thigh _____ |
| <input type="checkbox"/> Abdomen _____ | <input type="checkbox"/> Knee _____ |
| <input type="checkbox"/> Physical Maturity _____ | <input type="checkbox"/> Leg/ankle _____ |
| <input type="checkbox"/> Skin _____ | <input type="checkbox"/> Foot _____ |
| <input type="checkbox"/> Neurological _____ | |

___ Cleared ___ Not Cleared for: _____ Reason: _____

___ Cleared after completing evaluation/rehabilitation for: _____

Recommendations: _____

Name of Physician: _____ Phone: _____

Physician Signature: _____ **Date:** _____
