

Pre-Participation Physical Evaluation

PHYSICAL EXAMINATION

DATE OF EXAM _____

This page to be completed by physician / nurse practitioner/physician assistant

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP _____

Vision R 20/ _____ L20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDING	INITIALS *
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for:

Not cleared for [Sport(s)]: _____ Reason: _____

Recommendation: _____

Name of physician / **nurse practitioner /physician assistant (print/type) _____ Date: _____

Address: _____ Telephone: _____

Signature of physician /nurse practitioner/physician assistant _____
MD/nurse practitioner/physician assistant

Physicians Stamp:

Endorsed by the MPSSAA