

# SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION

Please Print

## Physical Examination Form

\_\_\_\_\_  
 Last Name                      First Name                      Middle Initial                      Date of Birth

Gender: \_\_\_ M \_\_\_ F                      Age: \_\_\_\_\_                      Grade: \_\_\_\_\_

**PHYSICAL EXAM** - To Be Completed By Physician or trained medical personnel under the supervision of a physician.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Medical	Normal	Abnormal Findings	Initials
1. Eyes (vision)			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck / Lymph Nodes			
5. Cardiovascular			
6. Abdomen			
7. Chest & Lungs			
8. Skin			
9. Genitalia-Hernia (male)			
10. Heart (squatting to standing & supine)			
Musculoskeletal: ROM, strength, etc.			
• Neck			
• Spine/Back			
• Shoulders/Arm			
• Elbow/Forearm			
• Wrist/Hand			
• Hip/Thighs			
• Knees			
• Leg/Ankles			

\_\_\_ Cleared without restriction

\_\_\_ Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_

\_\_\_ Not Cleared: \_\_\_ All Sports \_\_\_ Certain Sports: \_\_\_\_\_

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician or work directly with a licensed physician.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_