Rosary Academy

Pre-Participation Evaluation

PHYSICAL EXAMINATION

EXAM DATE: ____/____/____

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____ /_____; _____ /_____

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

MEDICAL	**Normal**	**Abnormal**	**Explain Abnormal Findings**	**Initials**
Appearance				
Head				
Eyes\Ears\Nose\Throat				
Lymph Nodes				
Heart				
Pulses				
Lungs				
Abdomen				
Skin				
Other				
ORTHOPEDIC	**Normal**	**Abnormal**	**Explain Abnormal Findings**	**Initials**
Neck				
Back				
Shoulder / Arm				
Elbow / Forearm				
Wrist / Hand				
Hip / Thigh				
Knee				
Leg / Ankle				
Foot				
Other				

Comments:

_____

_____

I certify that, on this date, I have examined the above student as indicated by the items checked above and recommend that the athlete is physically able to participate in supervised athletic activities as checked below:

_____ **Full-unlimited participation**

_____ Cleared after evaluation / rehabilitation for: _____

_____ No Athletic Participation Reason: _____

Physician's Signature: _____ Date: _____

PHYSICIAN STAMP: *If Physician's Assistant (P.A.) or Nurse Practioner (N.P.) performed the exam, name and address of collaborating physician or physician group.