PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name __________________________ Sex _____ Age _____ Date of Birth _________________

Height ________ Weight _________ Pulse __________ BP _____/______ (_____/______,_____/______)

Vision R20/______ L20/________ Corrected: Y N Pupils: Equal ____ Unequal ____

Physical Examination Form must be completed yearly prior to participation in any athletic event associated with TVS.

PHYSICIAN REMINDERS (For further comment by physicians)

- Do you feel stressed out or under a lot of pressure?
- Do you ever feel sad, hopeless, depressed or anxious?
- Do you feel safe at your home or residence?
- Have you ever tried cigarettes, chewing tobacco, snuff or dip?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
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 stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
Neck			
Back/Spinal Screen			
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: ____

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The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner will not be accepted.

Printed Name: ___________________________________ Date of Examination: ____________________

Address: _______________________________________ Phone Number: _________________________

Signature: ____

Must be completed before a student participates in any practice or games/matches.