**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_