Preparticipation Physical Evaluation - Physical Form

Last Name	First Name	Middle Initial	Date of Birth

Examination				
Height:	Weight:			
BP: / (/)	Pulse:	Vision: R 20/	L 20/	Corrected ___ Yes ___ No

Medical	Normal	Abnormal Findings
Appearance: Marfan stigmata (kyphoscoliosis, high–arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency		
Eyes / Ears / Nose / Throat - Pupils equal / Hearing		
Lymph Nodes		
Heart - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver		
Lungs		
Abdomen		
Skin - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
Neurologic		
Musculoskeletal:		
- Neck		
- Back		
- Shoulders/Arm		
- Elbow/Forearm		
- Wrist/Hand/Fingers		
- Hip/Thighs		
- Knees		
- Leg/Ankles		
- Foot/Toes		
- Functional: Double-leg squat test, single leg squat test, and box drop or step drop test		

Consider: electrocardiography (ECG), echocardiography, and referral to cardiologist for abnormal cardiac history or examination findings or a combination of those.

Preparticipation Physical Evaluation

___ Medically eligible for all sports without restriction.

___ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: _____

_____

___ Medically eligible for certain sports: _____

___ Not medically eligible pending further evaluation.

___ Not medically eligible for any sports.

Recommendations: _____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. If conditions arise after the athlete had been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete and parents or guardians.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____ MD, DO, NP, or PA

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