HEMET UNIFIED SCHOOL DISTRICT

ATHLETIC PHYSICAL SCREENING FORM

TO BE COMPLETED BY PHYSICIAN i.e., MD, DO, PA, NP, RNP, DC

Name_____ Social Security No._____ Sport_____

Height_____ Weight_____ Blood Pressure_____ Pulse_____ Temp_____

Vision; R20/_____ L20/_____ Corrective Lenses: Yes__ No__ Corrected Vision R20/____ L20/____

Immunization Dates: Measles or MR_____ TD or Tetanus_____

Physical Exam (Please elaborate on any abnormality in the history)

	Normal	Abnormal	Describe Abnormality in Detail
Head, Face and Scalp			
Mouth, Nose & Throat			
Tonsils in ( ) out ( )			
Ears			
Eyes			
Neck (thyroid)			
Lymph nodes			
Lungs and Chest			
Breasts			
Heart			
Vascular system			
Abdomen (include hernias)			
Genitalia			
Musculoskeletal (strength and range of motion)			
Neck			
Shoulders			
Elbows			
Hands/Wrists			
Spine			
Knees			
Ankles			
Feet			
Skin			
Neurological			

Assessment:

Recommendations/preventative measures:

CLEARANCE (CIRCLE APPROPRIATE CATEGORY)

1. No Limitations to contact/collision
2. Limited contact/impact
3. No – contact
   a. strenuous b. non-strenuous
4. Clearance deferred until seen by team physician or specialist

Physician's Name_____

Physician's Signature_____

Phone:_____ Date:_____

Attach Stamp or Business Card