

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: _____

