



**TO BE COMPLETED BY PHYSICIAN**

**MOUNT SI HIGH SCHOOL  
PHYSICAL EXAMINATION**

ATHLETE'S FULL NAME: \_\_\_\_\_

GRADE: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ % Body fat (optional): \_\_\_\_\_ Pulse:  
\_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected? Y N Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

Normal

<input type="checkbox"/> Appearance _____	<input type="checkbox"/> Neck _____
<input type="checkbox"/> Eyes/Ears/Nose/Throat _____	<input type="checkbox"/> Back _____
<input type="checkbox"/> Lymph Nodes _____	<input type="checkbox"/> Shoulder/arm _____
<input type="checkbox"/> Heart _____	<input type="checkbox"/> Elbow/forearm _____
<input type="checkbox"/> Pulses _____	<input type="checkbox"/> Wrist/hand _____
<input type="checkbox"/> Lungs _____	<input type="checkbox"/> Hip/Thigh _____
<input type="checkbox"/> Abdomen _____	<input type="checkbox"/> Knee _____
<input type="checkbox"/> Physical Maturity _____	<input type="checkbox"/> Leg/ankle _____
<input type="checkbox"/> Skin _____	<input type="checkbox"/> Foot _____
<input type="checkbox"/> Neurological _____	

\_\_\_ Cleared \_\_\_ Not Cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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