# Physical Examination

HEMET Unified School District

(Please type or print)

Student's Name _____ Birth Date _____
Last First Middle

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____/____

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

| | Normal | Abnormal Findings | Initials* |
|---|---|---|---|
| **MEDICAL** | | | |
| Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |
| **MUSCULOSKELETAL** | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |

*Station-based examination only

## Clearance

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

_____

☐ Not cleared for: _____ Reason: _____

Recommendations: _____

_____

_____

_____

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities (Note exceptions above).

_____
Physician's Name and Address (stamp or print)
If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.N.P.) performed the exam, name and address of collaborating physician or physician group:

_____

_____
Examiner's Signature Date

_____
Examiner's Telephone Number

NOTE: History and Consent Must be Completed Prior to Physical Examination

**Please upload completed physical form on AthleticClearance.com (online athletic registration for Hemet Unified School District High Schools)**