SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION

Please Print

Physical Examination Form

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

Gender: ___ M ___ F Age: _____ Grade: _____

PHYSICAL EXAM - To Be Completed By Physician or trained medical personnel under the supervision of a physician.

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Medical	Normal	Abnormal Findings	Initials
1. Eyes (vision)			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck / Lymph Nodes			
5. Cardiovascular			
6. Abdomen			
7. Chest & Lungs			
8. Skin			
9. Genitalia-Hernia (male)			
10. Heart (squatting to standing & supine)			
Musculoskeletal: ROM, strength, etc.			
• Neck			
• Spine/Back			
• Shoulders/Arm			
• Elbow/Forearm			
• Wrist/Hand			
• Hip/Thighs			
• Knees			
• Leg/Ankles			

____ **Cleared without restriction**

____ **Cleared, with recommendations for further evaluation or treatment for:** _____

_____

____ **Not Cleared:** ___ **All Sports** ____ **Certain Sports:** _____

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician or work directly with a licensed physician.

Physician's Signature: _____ Date: _____

Print Name _____

Physician's Address: _____