

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

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

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

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
 +Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: _____

Not Cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

MURRAY COUNTY SCHOOLS

PARTICIPATION CERTIFICATE – PHYSICIAN/PARENT/STUDENT

This form is to be completed prior to the first practice session. It contains vital information in case of injury. This form should accompany this athlete to all practices and contests.

Section 1: ATHLETE’S APPLICATION AND PERSONAL INFORMATION

NAME: _____ MALE ___ FEMALE ___ DATE OF BIRTH ___ / ___ / ___

ADDRESS _____ CITY/STATE _____

SPORT _____ GRADE IN SCHOOL _____

This application to represent my school in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have studied and understood the Eligibility Standards that I must meet to represent my school and that I have not violated any of them. I also understand that if I do not meet the standards set by the school or if I am ejected from any interscholastic contest because of an unsportsmanlike act, it could result in my not being allowed to participate in the next contest or suspension from the team either temporarily or permanently.

I have completed and/or verified that part of this certificate, which requires me to list all previous injuries, or additional conditions that are known to me which may affect my performance in so representing my school, and I verify that it is correct and complete.

SIGNED BY STUDENT _____ DATE ___ / ___ / ___

SECTION 2: PARENT PERMISSION AND AUTHORIZATION FOR TREATMENT

We hereby give our consent for the above student to represent his/her school in interscholastic athletics.

If we cannot be reached and in the event of an emergency, we also give consent for the school to obtain through a physician or hospital of its choice, such medical care as is necessary for the welfare of the student, if he/she is injured in the course of school athletic activities.

We further state that we have completed that part of this certificate, which requires us to list all previous injuries, or additional conditions that are known to us which may affect this athlete’s performance or treatment and we certify that it is correct and complete.

The school provides that a student shall not be permitted to practice or compete for a school until it has verification that he/she has basic athletic insurance coverage. Our son/daughter is covered by basic accident insurance for the current year.

NAME OF INSURANCE CO. _____ POLICY # _____

SIGNATURE OF PARENTS OR GUARDIANS (ALL PARENTS OR GUARDIANS MUST SIGN) DATE ___ / ___ / ___
