



This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.
 Disclaimer: Athletes must have physical examination clearance yearly, current, and on file during sport participation.

Physician's Stamp Required Here

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
COVID-19 VACCINE		
Previously received COVID-19 vaccine: <input type="checkbox"/> Y <input type="checkbox"/> N		
Administered COVID-19 vaccine at this visit: <input type="checkbox"/> Y <input type="checkbox"/> N If yes: <input type="checkbox"/> First dose <input type="checkbox"/> Second dose <input type="checkbox"/> Third dose <input type="checkbox"/> Booster date(s) _____		
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Cleared for sport participation Not Cleared for sport participation – Reason: _____

Name of health care professional (print or type): _____ Date: _____

Signature of health care professional: _____, MD, DO, NP, or PA