CALVARY CHAPEL CHRISTIAN SCHOOL

Pre-Participation Physical Evaluation

Name:_____ Date of Birth:___/___/_____

To Be Completed by Physician

Height:_____ Weight:_____ Pulse:_____ BP:_____

Vision: R 20/_____ L 20/_____ Corrected: (Circle) Y N Pupils: Equal_____ Unequal_____

Medical	Normal	Abnormal Findings	Initials
Appearance			
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:_____

_____

_____

Name of Physician (print/type):_____ Phone:(___)_____

Address:_____

Signature of Physician:_____ Date:_____