

# Spring Hill Christian Academy

3140 Mariner Blvd., Spring Hill, FL 34609

## Part 3. Physical Examination. (To be completed by physician).

Student's Name: \_\_\_\_\_ Student # \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_ Weight: \_\_\_\_ % Body Fat (optional): \_\_\_\_ Pulse: \_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_/\_\_\_\_)

Visual Acuity: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Corrected: Yes No Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
<b>MUSCULOSKELETAL</b>			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Arm	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____
* - station-based examination only			

## ASSESSMENT OF EXAMINING PHYSICIAN

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):  
\_\_\_\_ Cleared without limitation.  
\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
\_\_\_\_ Referred to \_\_\_\_\_ For: \_\_\_\_\_  
Recommendations: \_\_\_\_\_  
Name of Physician (print or type): \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Signature of Physician: \_\_\_\_\_, MD, DO, DC, ARNP

## ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):  
\_\_\_\_ Cleared without limitation.  
\_\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
\_\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
Recommendations: \_\_\_\_\_  
Name of Physician (print or type): \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Signature of Physician: \_\_\_\_\_, MD, DO, DC, ARNP

Based on recommendations developed by the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and American Osteopathic Academy for Sports Medicine.