

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*
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitalia (males only)	_____	_____	_____
9. Skin	_____	_____	_____
MUSCULOSKELETAL			
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.