



HENDERSON
INTERNATIONAL
SCHOOL

STUDENT PRE-ATHLETIC PHYSICAL EXAMINATION
This form must be completed in order to participate in afterschool athletics.

Student's Name: _____ Date of Birth: _____ Date of Physical Examination: _____

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

Vision: R 20/ _____ L 20/ _____ Glasses/Contacts: Yes No Hearing: Right _____ Left _____

	Normal	Abnormal Findings	Initials *
Medical			*station-based examination only
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/Oropharynx			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/Hernia			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

Not Cleared For: _____ Reason: _____

Recommendations: _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of Physician: _____ MD / DO / NP / PA-C