

PHYSICAL EXAMINATION PRE-PARTICIPATION PHYSICAL EVALUATION

Participant Name: _____

Date of Birth: _____ Grade _____ HS Area _____

Vision R 20/ _____ L 20/ _____ Corrected Y N _____ HR: _____ BP: _____ / _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL	NKA	Allergies to food or medication:	
Appearance			
Eyes/Ears/Nose/Throat			
Heart			
Pulses			
Lungs		Asthma? Do you use an inhaler?	
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL		Prior Injury/Concussion: How many? When?	
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

Cleared for all KCFC activities Not cleared for: _____

Reason: _____

Recommendation: _____

**I HEREBY CERTIFY THAT I AM QUALIFIED BY TRAINING AND EXPERIENCE TO PROPERLY
PERFORM THE EXAMINATION AND MAKE THE EVALUATION REFLECTED ON THIS FORM.**

Name of Physician (print/type) _____ Date _____

Address _____ Phone _____

Signature _____ MD, DO, DC, RPA