

WICOMICO COUNTY PHYSICAL EXAMINATION FORM

To be completed by a board certified physician, physicians assistant or nurse practitioner

Date of Examination ____/____/____

Student's Name _____ Social Security # _____

Age ____ Date of Birth ____ Height ____ Weight ____

Blood Pressure _____ Pulse _____

Vision R20/____ L20/____ Corrected Y N Corrected Lenses ____ Pupils ____

PHYSICAL REVIEW

Head & Scalp _____

Ears _____

Nose & Sinus _____

Throat-Tonsils-Adenoids _____

Thyroid _____

Teeth & Gums _____

Chest/Lungs _____

Respirations _____

Breast & Nodes _____

Cardiovascular _____

Heart Rate & Rhythm _____

Murmurs _____

Other _____

Abdomen _____

Scars, tenderness or nausea _____

Buttocks _____

Hemorrhoids _____

Pilonidal Cyst _____

Recommendations for Lifestyle Modifi-

cation (i.e.) weight loss) _____

Genitalia _____

Hernia _____

Paired & Functioning Organs _____

Musculoskeletal _____

Injuries or Defects _____

Spine: Posture _____

Shoulders _____

Lower Arm, Hand & Fingers _____

Torso: Posture _____

Knees, Ankles & Feet _____

Skin _____

Central Nervous System _____

Pupil Response _____

Reflexes _____

Coordination _____

Immunizations _____

Tetanus _____ Date _____

Pertinent History _____

General Summary of Physical Examination

Clearance: This section must be completed, signed and stamped by the attending Practitioner

A. Cleared for Full Activity in ALL Sport Competition YES _____ NO _____

EXPLANATION: _____

B. Cleared After Completing Evaluation/Rehabilitation for _____

C. CLEARED FOR: YES _____ NO _____ Collision (Football, Lacrosse, Rugby)
YES _____ NO _____ Contact (Basketball, Baseball, Softball, Hockey, Soccer)
YES _____ NO _____ Noncontact (Track, Cross Country, Swimming, Golf)

Due to _____

Recommendations: _____

Name of Practitioner (Print or Stamp) _____ Date _____

Address _____ Telephone _____