SALISBURY
CHRISTIAN SCHOOL

Wicomico County Physical Examination Form

(to be completed by a board certified physician, physician assistant, or nurse practitioner)

Date of Examination: _____

Student Name: _____

Social Security Number: _____

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 Modifications (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 and signed or stamped by the attending practitioner.

A. **Cleared for full activity in ALL sport competition: YES**_____**NO** _____
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** _____ **Non-contact** (track, cross country, swimming, golf)

Due to: _____
Recommendations: _____

Name of Practitioner (print or stamp): _____ Date: _____
Address: _____ Telephone: _____