Name:_________________________ DOB:_______________ Date of Exam:_________

Physical Examination (To be completed by Licensed Healthcare Provider)

| Height: ___________ | Weight: ___________ | Pulse: _________ | BP: ________ / ________ |

| Vision (R): __________ | Vision (L): __________ | Corrected? ☐ Yes ☐ No |

Examination

System/Area	Normal	Abnormal	Notes
General Appearance	☐	☐	
Eyes/Ears/Nose/Throat	☐	☐	
Cardiovascular	☐	☐	
Respiratory	☐	☐	
Abdomen	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin	☐	☐	

Clearance

☐ Cleared for all sports without restriction
☐ Cleared with the following restrictions:
____

☐ Not cleared for sports (reason):
____

Provider's Signature: ____
License # : ______________________________________
Date: ___ / ___ / ______