Heath Center - Physical Exam with Sports Clearance

CADET/CAMPER Last Name	CADET/CAMPER First	D.O.B:

PHYSICIAN EXAMINATION:

Complete a thorough review of systems. **Please indicate fields are within normal limits (WNL) or describe abnormalities in detail.**

Any necessary treatment or referrals should be completed *_prior_ to attendance.

All physicals must be on this form, translated in English.

- **Exam must be completed every 12 months by a licensed medical practitioner**

Height _____	Weight _____	Blood Pressure _____	Pulse _____
Head _____	Eyes _____	Ears _____	Nose _____
Throat / Mouth _____	Neck _____	Thyroid _____	Neurological _____
Lungs _____	Heart _____	Abdomen _____	Genitalia / Hernia _____
Back _____	Shoulder / Arm _____	Extremities _____	Elbow / Forearm _____
Wrist / Hand _____	Hip / Thigh _____	Knee _____	Leg / Ankle _____
Foot _____	Skin _____	BMI _____	Nutritional Status _____
Anxiety _____	Depression _____	ADD/ADHD _____	Other Psych Problem _____

VISION: R 20/___ L 20/ ___ Corrected: Yes ___ No ___ Comments: _____

HEARING: Within Normal Range: Yes ___ No ___ Abnormalities? _____

MEDICATIONS: Does the student take any medication including routine, OTC'S, and supplements?

☐ Yes ☐ No ***If Yes**, **complete Medication Authorization Form**

***SPORTS PARTICIPATION: Is the student cleared for participation in sports (MANDATORY Check one):**

☐ **Yes** ☐ **No**

Please describe in detail any condition which would prevent or limit _full_ participation in all areas of athletics, marching, rifle drill, or academics. State diagnosis, prognosis, and specify duration (including dates) of any limitations or restrictions:

_____
_____
_____
_____

I have examined the above student on this date: _____/_____/_____ Office Stamp and/or Seal required:

Practitioner's Signature: _____

Printed Name: _____ Title: _____

Address: _____

Phone: _____ **Fax:** _____