2700 W. Sam Houston Parkway N.
Houston, Texas 77043
713-580-6000
Fax 713-580-6001

2016- 17 Athlete/New Student Physical

Must be completed and faxed, mailed or hand delivered to the school nurse before a **new** student's first day of class or for **any** student prior to any practice (before, during or after school), in season or out of season, games, matches or competitions.

Printed Student Name ____

Nickname ______________________________ Date of Birth ______________

The above named student has my permission to obtain this physical.

Parent Signature ____

Height__________ Weight__________ Pulse__________ Blood Pressure_______/_______

Vision R 20/____ L 20/______ Corrected ☐☐ Yes ☐☐ No Contacts______ Glasses______ Pupils Equal_____ Unequal _____

Scoliosis Screening ☐☐ Pass ☐☐ Fail

Acanthosis Nigricans ☐☐ Yes ☐☐ No

TB Skin Test ☐☐ Yes ☐☐ No ☐☐ Pos ☐☐ Neg

Measles ☐☐ Yes Date____________ ☐☐ No

Mumps ☐☐ Yes Date____________ ☐☐ No

Hearing (@ 25 db)	500 Hz	1000 Hz	2000 Hz	4000 Hz
Right				
Left				

Medical	Normal	Abnormal Findings	Not Evaluated
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart supine			
Heart-Auscultation of the heart standing			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

Musculoskeletal

Neck			
Back			
Chest			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Comments regarding abnormal findings ____

Cleared to participate ☐☐ Yes ☐☐ No

Cleared after completing evaluation and/or rehabilitation for ______________________________

Not cleared for ______________________________ Reason ______________________________

Recommendations ____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Chiropractic examinations will not be accepted.

Printed Name of Physician ______________________________ Date of Exam ______________

Physician Phone Number ____

Physician Address ____

Physician Signature ____