

PHYSICAL EXAMINATION PRE-PARTICIPATION PHYSICAL EVALUATION

Participant Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Vision R 20/ _____ L 20/ _____ Corrected Y N _____ BP _____ / _____

Record date of most recent immunization (shot) for Td _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Heart			
Pulses			
Lungs			
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL			
Prior Injury Y N			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*Station-based examination only

CLEARANCE

Cleared for all FCCJC activities Not cleared for: _____

Reason _____

Recommendation _____

**I HEREBY CERTIFY THAT I AM QUALIFIED BY TRAINING AND EXPERIENCE TO PROPERLY
PERFORM THE EXAMINATION AND MAKE THE EVALUATION REFLECTED ON THIS FORM.**

Name of Physician (print/type) _____ Date _____

Address _____ Phone _____

Signature _____ MD, DO, DC, RPA