PHYSICAL EXAMINATION
PRE-PARTICIPATION PHYSICAL EVALUATION

Participant Name:_____

Date of Birth:_____Grade_____HS Area_____

Vision R 20/ L 20/ Corrected Y N HR: BP: /

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL	NKA	Allergies to food or medication:	
Appearance			
Eyes/Ears/Nose/Throat			
Heart			
Pulses			
Lungs		Asthma? Do you use an inhaler?	
Genitalia/Hernia			
Skin			
MUSCULOSKELETAL		Prior Injury/Concussion: How many? When?	
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

HEALTH HISTORY:

CLEARANCE

☐ Cleared for all KCFC 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

2024