COLUSA HIGH SCHOOL SPORTS PARTICIPATION MEDICAL EXAMINATION

To be completed by the Physician, RN, APRN, or PA.. This medical examination is valid for one calendar year from date of exam.*

Name_____ Date of Birth_____ ***Date of Exam***_____

General Exam

	Normal	Abnormal Findings
Appearance		
Skin		
HEENT		
Respiratory		
Cardiovascular		
	Arrhythmia	
	Murmur	
Abdomen		
Neurological		
Genitalia (hernia)		
Physical Maturity (Tanner Stage) 1 2 3 4 5		

Height_____ Weight _____
Blood Pressure_____ Pulse_____
HCT/HGB _____
Visual Acuity _____ Right_____Left
Corrected to_____ Right_____Left
Hearing _____

Body Fat (Optional)_____%
Cholesterol (Optional) _____

Last Tetanus Booster Date:_____
HBV 1_____2_____3_____

Chronic Disease Assessment

_____ Asthma: ☐mild ☐moderate ☐severe ☐exercise induced ☐unclassified
_____ Diabetes: ☐Type I ☐Type II
_____ Anaphylactic Reaction: ☐food ☐insect ☐latex
_____ Seizure Disorder
_____ Other: Please specify_____

Orthopedic Exam

Musculoskeletal Evaluation: to include range of motion, strength, and flexibility

	Normal	Abnormal Findings
Neck		
Spine		
Postural		☐Min. ☐Slight ☐Mod. ☐Marked
Shoulders		
Arms / Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		

Recommendations

Weight loss/gain _____ Medications _____
Strengthening _____ Special Equipment_____
Stretching _____ Bracing/Taping _____
Conditioning (endurance) _____

***I certify that on this date I have examined this student and that, on the basis of the examination requested by school authorities and the student's medical history, as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those listed below:**

_____ _____ _____
Signature of Physician, RN, APRN, PA *Telephone* *Provider Print or Stamp*