

CLOVIS USD SPORTS PRE-PARTICIPATION SCREENING FORM

This form MUST be completed for every sports participant with parent & athlete signature

Student's Name _____ Sex M or F Date of Birth _____

Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: ____/____ Hgb: _____

Vision: Grossly Intact _____ Corrected: Y or N Pupils: Equal _____ Unequal _____

Physical Screening	Normal Findings	X	Abnormal Findings	No Exam
Appearance	WDWN			
Eyes/Ears/Nose/Throat	WNL			
Lymph Nodes	WNL			
Hearing	Grossly Intact			
Heart	RRR, No Significant Murmur			
Pulses	WNL			
Lungs	Clear/equal			
Abdomen	Soft, No HSMT			
Skin	Warm/Dry/Intact			
Neck	FROM			
Back	No Scoliosis			
Shoulder/Arm/Elbow	FROM, = strength			
Forearm/Wrist/Hand	FROM, = grip/strength			
Hip/Thigh/Knee	FROM			
Leg/Ankle/Foot	FROM			
Hernia/Squat/Duck Walk	WNL			
Immunizations given				

CLEARANCE

Cleared

NOT Cleared until completed evaluation/rehabilitation for: _____

Not cleared for: _____ Reason: _____

Recommendations: _____

Name of Health Care Provider (print/type/stamp): _____ Date of exam: _____

Address: _____ Phone: _____

Signature of Health Care Provider: _____ Date of signature: _____

This form was developed based upon guidelines from the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Academy of Sports Medicine, 2009.