

SOUTH CAROLINA INDEPENDENT SCHOOL ASSOCIATION

Please Print

Medical Examination Form

 Last Name First Name Middle Initial Date of Birth

Gender: M F SS# _____ Age: _____ Grade: _____

PHYSICAL EXAM - To Be Completed By Physician

Height _____ Weight _____ Pulse _____ Blood Pressure _____

	Normal	Abnormal Findings	Initials
1. Eyes (vision)			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular			
6. Abdomen			
7. Chest & Lungs			
8. Skin			
9. Genitalia-Hernia (male)			
10. Musculoskeletal: ROM, strength, etc.			
• Neck			
• Spine			
• Shoulders			
• Arms/hands			
• Hips			
• Thighs			
• Knees			
• Ankles			
11. Neuromuscular			

Your general assessment of health (limitation, referrals, etc.) _____

Notice to Parents: urinalysis and hematocrit/hemoglobin are optional. Parents should consider both test in order to provide additional medical information.

I certify that I have examined this athlete on this date and found him/her medically qualified to participate in sports. I also certify that I am a licensed physician.

Physician's Signature: _____ Date: _____

Physician's Address: _____