

Oxnard Union High School District PREPARTICIPATION PHYSICAL EXAMINATION FORM

Athlete Name: _____ Date of Birth: _____

EXAMINATION		
Height:	Weight:	BP: / (/) Pulse:
Vision corrected: Y / N	Pupils equal: Y / N	
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Hernia		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

^aConsider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Allergies: _____ Regular Medications: _____

Comments: (asthma, diabetes, etc.) _____

CLEARED FOR ATHLETICS **NOT CLEARED- Reason:** _____

Name of Examiner (print): _____ State License#: _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

Provider Stamp or Attached Business Card:

Grade: _____

School: _____

First Name: _____

Sport(s): _____

Last Name: _____

Student ID#: _____

*Parent/ Guardian and Student Consent on Next Page must be filled out by Parent and Student for athlete to be cleared.

Parent/Guardian and Student Consent

I hereby give my consent for _____, hereafter named student, to compete in athletics. I authorize the student to go with and be supervised by a representative of the school on any trips. In case this student becomes ill or is injured, you are authorized to have the student treated and I authorized the medical agency to render treatment. I consent to evaluation and treatment by the Certified Athletic Trainer, any X-ray examination, anesthetic, medical , or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital it is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the school representative to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgement may deem advisable. This authorization shall remain effective until the end of the school year unless sooner revoked in writing and delivered to the school.

Parent/ Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____