

Stratton Mountain School

Pre-participation Physical Evaluation/Well Exam

Required every 2 years – completed and signed by medical provider

Immunization Record: Please attach a complete record

Athlete's Name: _____ DOB: _____

Allergies: _____ Major Medical Conditions: _____

Height: _____ Weight: _____ BP: _____ / _____ Pulse: _____ bpm					
Vision: R 20/____ L 20/____ Corrected: Y N					
	Normal		Abnormal findings/comments		
Cardiopulmonary					
Pupils					
Hearing					
Pulses					
Lungs					
Physical Maturation Tanner stage	1	2	3	4	5
Skin					
Abdominal					
Genitalia					
Musculoskeletal					
Neck Shoulder					
Elbow					
Wrist					
Hand					
Back					
Knee					
Ankle					
Foot					
Neurological Balance/coordination					

Clearances:

- Cleared
- Cleared after completing evaluation/rehabilitation for: _____
- Not cleared for:
 - Contact/Collision
 - Limited Contact
 - Noncontact: __ Strenuous __ Moderately Strenuous __ Non-strenuous

Limitations due to: _____

Signature of physician: _____

Date of Exam: _____

Printed Name: _____

Clinic/Hospital: _____

Address: _____

Phone: _____