



Bishop Machebeuf High School- Physical Form

**A physician's signature is required below*

I hereby certify that I have examined _____ and that the student was found physically fit to engage in high school sports (except as listed below.)

Student's Date of birth _____ Expiration Date (good for 365 days) _____

Complete	Limited	Height: _____ Weight: _____ BP ____/____ Pulse _____ G		
		Vision R 20/____ L 20/____ Corrected: Y N Pupils _____ G		
		Normal	Abnormal Findings	Initials
	Cardiopulmonary			
	Pulses			
	Heart			
	Lungs			
	Tanner Stage			
	Skin			
	Abdominal			
	Genitalia			
	Musculoskeletal			
	Neck			
	Shoulder			
	Elbow			
	Wrist			
	Hand			
	Back			
	Knee			
	Ankle			
Foot				
Other				

Clearance

- a. Cleared
- b. Cleared after completing evaluation/rehabilitation for: _____
- c. Not cleared for Collision contact
 Non-Contact Strenuous Moderately Strenuous Non-Strenuous

Recommendation _____

Name of Physician/Nurse Practitioner/Certified-Registered Chiropractor: _____

Address: _____

Signature of MD/DO, PA, NP, DC-SPC# _____

Date: _____