

# PORT ANGELES HIGH SCHOOL

## DEPARTMENT OF ATHLETICS

304 East Park Avenue  
Port Angeles, WA 98362  
360.565.1809



### FORM MUST BE COMPLETED BY STUDENT'S PHYSICIAN EVERY 24 MONTHS.

*Physical Examination form must be returned with Athletics Application Package.*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Height _____ Weight _____ BP _____ / _____ Pulse _____			
Vision R20/ _____ L20/ _____ Corrected: Y N			
	Normal	Abnormal Findings	Initials
HEENT			
Pupils equal?			
Heart			
Pulses			
Lungs			
Abdominal			
Musculoskeletal (Symmetry/ROM/Strength/Flexibility)			
Neck			
Back			
Shoulder			
Elbow			
Wrist			
Hand			
Hip			
Knee			
Ankle			
Foot			

No restriction for sports participation  
 Clearance withheld pending attached verification of rehabilitation/evaluation for: \_\_\_\_\_

Limited participation. Not cleared for the following types of sports: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Print Name and Address \_\_\_\_\_