Culver City Unified School District
Physical Examination Form

To be completed by physician/provider

Student's Name: _____ Sex: M / F Age: ____ Birthdate: _____
Height: _____ Weight:_____ %BMI (optional): _____ HR: _____ BP: _____/_____ (_____/_____, _____/_____)
Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____ Comments: _____

Emergency Information
Allergies: _____
Other: _____

MEDICAL	Normal Findings	Abnormal Findings
Appearance: Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyper laxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose Throat: Pupils Equal Hearing		
Lymph Nodes:		
Heart: 1 Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)		
Lungs:		
Abdomen:		
Genitourinary (males only): 2		
Skin: HSV lesions suggestive of MRSA, tinea corporis		
Neurologic: 3		
MUSCULOSKELETAL	**Normal Findings**	**Abnormal Findings**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/ankle		
Foot/Toes		
Functional (Duck Walk, single leg hop)		

1 Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam
2 Consider GU exam if in private setting. Having 3rd party present is recommended.
3 Consider cognitive evaluation or baseline neuropsychiatric setting if a history of significant concussion.

CLEARANCE

Cleared for all sports without restriction ☐
Cleared for all sports without restriction with recommendations for further evaluation or treatment for: _____
Not Cleared for ANY sport for certain sports: _____ Pending further evaluation or for the following reason: _____

I have evaluated the above named student and completed the physical examination. The athlete does not present apparent contraindications to practice, tryout, and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).
Name of Provider (print/type): _____(MD, DO, NP, or PA)

Address: _____ Phone: _____
Signature of Provider: _____ Date: _____

Place Health Provider/Physician Stamp Here (Required for Verification)