

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.

Form must be returned with Athletics Application Package.

Name _____ Age _____ 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 _____

Revised 04/2010