CLOVIS USD SPORTS PRE-PARTICIPATION SCREENING FORM
This form MUST be completed for every sports participant with parent & athlete signature

Student’s Name ____________________________ Sex M or F Date of Birth __________

Height: ______  Weight: ______  BMI: ______  Pulse: ______  BP: _____/_____

Vision: Grossly Intact ____  Corrected: Y or N  Pupils: Equal ____ Unequal ____

<table>
<thead>
<tr>
<th>Physical Screening</th>
<th>Normal Findings</th>
<th>X</th>
<th>Abnormal Findings</th>
<th>No Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>WDWN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/Ears/Nose/Throat</td>
<td>WNL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td>WNL</td>
<td></td>
<td></td>
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<tr>
<td>Hearing</td>
<td>Grossly Intact</td>
<td></td>
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</tr>
<tr>
<td>Heart</td>
<td>RRR, No Significant Murmur</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td>WNL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td>Clear/equal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>Soft, No HSMT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>Warm/Dry/Intact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td>FROM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td>No Scoliosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder/Arm/Elbow</td>
<td>FROM, = strength</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forearm/Wrist/Hand</td>
<td>FROM, = grip/strength</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh/Knee</td>
<td>FROM</td>
<td></td>
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<td></td>
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<tr>
<td>Leg/Ankle/Foot</td>
<td>FROM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia/Squat/Duck Walk</td>
<td>WNL</td>
<td></td>
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<tr>
<td>Immunizations given</td>
<td></td>
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</tr>
</tbody>
</table>

CLEARANCE

☐ Cleared

☐ NOT Cleared until completed evaluation/rehabilitation for: ________________________________

_________________________________________________________________________________

☐ Not cleared for: ________________________________  Reason: ________________________________

☐ Recommendations: ________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Name of Health Care Provider (print/type/stamp): ___________________________ Date of exam: ________
Address: ___________________________ Phone: __________

Signature of Health Care Provider: ___________________________ Date of signature: __________

This form was developed based upon guidelines from the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Academy of Sports Medicine, 2009.

Rev: 5/2/2018
I hereby state, that to the best of my knowledge, my answers to all the above questions are correct and complete and I take full responsibility for any incorrect answers.

Signature of Athlete ___________________________ Signature of Parent/Guardian ___________________________ Date __________