

William S. Hart Union High School District

2023-2024

CERTIFICATE OF PHYSICAL EXAMINATION

Must be completed by a licensed physician (MD/DO), nurse practitioner (NP) or physician assistant (PA)

Due to new district guidelines, physicals can not be completed by a Chiropractor or parent.

Name _____ DOB ____/____/____

Height _____ Weight _____ Pulse _____ BP _____/_____

Please put a "✓" as either Normal or Abnormal for all findings below. Please describe in detail, all abnormal findings.

Table with 4 columns: Finding, NORMAL, ABNORMAL, Comments. Rows include Heart, Pulse, Lungs, Neck, Back, Shoulder/Arm, Wrist/Hand, Hip/Thigh, Knee, Leg/Ankle/Foot, and Other pertinent medical findings.

Additional Comments: _____

List any restrictions and duration: _____

I hereby certify that the above-named student was examined by me on _____ (date) and found to be physically fit to engage in athletics.

Medical Provider's Signature _____

Stamp name or attach card of medical office here ↓