THE JOHN CARROLL SCHOOL

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Bel Air, Maryland 21014
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New Student and Athletic Physical Form

INSTRUCTIONS: This is the student's confidential medical record only to be shared with Faculty/Staff if pertinent. Must be performed by M.D., D.O., PA, or Nurse Practitioner. PLEASE INCLUDE A PHYSICIAN SIGNED COPY OF IMMUNIZATION RECORDS.

Student Name: ____ DOB: ________________ M / F: __________ Yr. of Grad: ______________

Student Height: ____________________________ Weight: ________________________ BP: _________________ Pulse: _____________

Vision: R 20/_____ L 20/_____ Corrected? Y_____ N_____ Hearing: Pass _______ Fail_______

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
MUSCULOSKELETAL			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE:
□ **Cleared**
□ **Cleared after completing evaluation/rehabilitation for**: ____
□ **NOT cleared for** [Sport(s)]: ________________________________ **Reason**:____

Recommendation: ____

Name of Physician/Nurse Practitioner/Physician's Assistant: ____**Date**:_______________
Address:____**Phone**:____________________________________

Signature of Physician/Nurse Practitioner/Physician Assistant: ____

I hereby certify that I have reviewed the student pre-participation Health History Questionnaire Form and performed a comprehensive initial pre-participation physical evaluation of the herein named student within the previous 365 days of signature. On the basis of such evaluation and the review of a current History Form, I certify that the student is physically fit to participate in an interscholastic sports program for the current school year.

Physician Stamp: