



PHYSICAL EXAMINATION FORM

Student Name: _____ D.O.B _____

Sport: _____

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- CLEARED WITHOUT RESTRICTIONS**
- Cleared **AFTER** further evaluation or treatment for: _____
- Cleared for **Limited participation** (check and explain "reason" for all that apply):
 - Not cleared for (specific sport) _____
 - Cleared only for (specific sport) _____
- Reason(s): _____
- Other Recommendations: _____
 - Recommended monitoring during early condition because of weight/fitness/other
 - Recommended restrictions or monitoring of weight loss or gain
 - Other: Reasons: _____

MD/DO, PA, NP, DE-SPC#, Signature: _____

Date of Examination: _____ Date Signed: _____

NAME OF PHYSICIAN/PA/NURSE PRACTICIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print): _____

Address: _____

City: _____ State: _____ Zip: _____

Nurse Practitioner
School Based Health Clinic
South High School
1700 E. Louisiana Avenue
Denver, CO 80210
720-423-6260

Student: