Hope Elementary School
SPORTS PHYSICAL EXAMINATION

Name: ______________________________ DOB ______________

Date of Examination: __________________

Height: __________ Weight: _________

BP: _____/_____ Heart rate: ________ Vision: R20/___ L20/___

I have examined the above student and I make the following recommendations for his/her participation in athletics:

________ CLEARED WITHOUT RESTRICTIONS

________ CLEARED WITH RESTRICTIONS
Restriction(s): ____
____

________ NOT CLEARED FOR PARTICIPATION
Reason(s): ____

Additional comments: ____
____

__By this signature, I attest that I have examined the above student and completed this pre-participation sports physical and I have obtained a full medical history.

Physician Signature: ____
Examiner's Name (printed): ______________________________ Title: _____
Phone Number: __________________ Fax Number: __________________
Address: ____ City: ____________________
State: _________ Zip Code: ______________
Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practioner or Physician's Assistant licensed to practice in the United States will be accepted.
TO PARTICIPATE IN SCHOOL SPONSORED SPORTS YOUR CHILD MUST ALSO PROVIDE PROOF OF SCHOOL, STATE OR PRIVATE HEALTH INSURANCE.

Please return : Attention School Nurse
34 Highfield Rd
Hope, ME 04847