

**HOUSTON INDEPENDENT SCHOOL DISTRICT  
ATHLETIC DEPARTMENT  
PHYSICAL EXAMINATION FORM**

The physical examination must be performed by a physician licensed to practice medicine in the state of Texas under the Medical Practice Act, i.e., a medical doctor (M.D.) or a doctor of osteopathy (D.O.). The University Interscholastic League and HISD rules require this report to be completed and the exam to have been passed before a student participates in any tryouts, practices, games, or off-season programs.

When in the judgment of school staff members there appears to be a change in the physical status of an athlete after the physician's report is completed, the school may require another physical examination, and a release by the physician must then be obtained before an athlete will be allowed to continue in an activity.

**Physicals must be completed no sooner than May 15 preceding the current school year.**

Student's Name: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L/20 \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS*
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart Auscultation of the heart in the standing position.			
Heart Lower-extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Previous surgery \_\_\_\_\_

Is student taking any medication routinely?  Yes  No (If yes, explain) \_\_\_\_\_

Allergic to any medication? \_\_\_\_\_

**CLEARANCE**

Cleared: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

**Do not sign if student fails physical.**

\_\_\_\_\_  
Stamp (or print) Name of Physician

\_\_\_\_\_  
Signature of Examining Physician (M.D. or D.O. only)

\_\_\_\_\_  
Address Phone #

\_\_\_\_\_  
Date of Physical Examination

Original for school file  
Copy for Stadium Athletic Trainer  
Copy for physician, if needed

\_\_\_\_\_  
State License Number

