

PLYMOUTH-CANTON COMMUNITY SCHOOLS
DEPARTMENT OF ATHLETICS, HEALTH AND PHYSICAL EDUCATION

PRE-PARTICIPATION PHYSICAL EXAM

Date: _____

School Attending: Canton Plymouth Salem

Name: _____ Address: _____

Grade: ____ Age: ____ Birthdate: _____ Sex: M F Home Phone: _____ Zip Code
ID#: _____

Parent/Guardian Names: _____ Work Phone: (____) _____
Cell Phone: (____) _____

Sports participating in for school year (circle)

Baseball	Cross Country	Gymnastics	Pom Pon	Swimming	Wrestling
Basketball	Football	Ice Hockey	Soccer	Tennis	Volleyball
Cheerleading	Golf	Lacrosse	Softball	Track	

Athletic Trainers

Height: _____ Pulse: _____ Gross Vision: R _____ L _____

Weight: _____ Blood Pressure: _____ / _____ Glasses: _____ / Contacts: _____

Urine Analysis: _____ Sit & Reach Flexibility: _____

Ears, Nose, Throat

Ears: _____ Nose: _____

Throat: _____ Lymph Nodes: _____

Cardiac Respiratory

Heart: _____

Lungs: _____

Orthopedic Exam

1. Neck: _____ 5. Knees _____

2. Shoulders: _____ 6. Ankles _____

3. Elbows: _____ 7. Low Back: _____

4. Wrist: _____ 8. Scoliosis: _____

Hernia Present: _____

Physicians Comments: _____

PLEASE
CIRCLE
ONE

- A. No athletic participation
- B. Limited participation with specific sport mentioned
- C. Clearance withheld until additional test, examinations or rehabilitation can be completed
- D. No reason found to restrict participation

Physicians Signature: _____ **Date:** _____

Parent (Guardian) Signature: _____ **Date:** _____

Skinfold Measurements

Triceps: _____ Suprailiac: _____
Scapula: _____ Biceps: _____
% Body Fat: _____

Physician's signature must be dated on or after April 15 of the current year to be accepted. Parents: page two must be completed and attached before returning to coach.

