Annual Physical Exam & Clearance for Physical Activity Form

To be completed and signed by a healthcare professional.

Santa Fe Indian School P.O. Box 5430 Santa Fe, NM 87505 | Telephone: (505) 989-6370 | Fax (505) 989-6338 | www.sfindianschool.org

Student Name: _____ DOB: _____ Grade: _____ F☐ M☐
Last Name, First Name, MI

List past and current medical conditions:

Have you ever had surgery? If yes, please list all past surgical procedures.

Medicines and supplements: List all current prescriptions, over-the counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (i.e., medicines, pollens, food, stinging insects).

EXAMINATION

Height:	Weight:	BP: / (/) Pulse:	Vision: R 20/	L 20/	Corrected: ☐Y ☐N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver [a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history of examination findings, or a combination of those.		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

☐ Medically eligible for physical activities, including sports, without restriction

☐ Medically eligible for physical activities with recommendations

☐ Not medically eligible for physical activities

Recommendations:

I have examined the student named on this form and completed the preparticipation physical examination.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of healthcare professional: MD, DO, NP, or PA

Form created April 2021