6.4A

**RETURN TO ATHLETIC DIRECTOR**

# William S. Hart Union High School District

## CERTIFICATE OF PHYSICAL EXAMINATION

Name_____ DOB____/____/____

Height_____ Weight_____ Pulse_____ BP_____/_____

Please place a "✔" as either Normal or Abnormal for all findings below. Please describe in detail all abnormal findings.

| | Normal | Abnormal | Comments |
|---|---|---|---|
| Heart | | | |
| Pulses | | | |
| Lungs | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle/Foot | | | |
| Other pertinent medical findings | | | |

Additional comments:_____

_____

_____

List any restrictions and duration:_____

_____

I hereby certify that _____ was examined by me on_____ 20____

and found to be physically fit to engage in athletics.

**Physician's Signature**_____ **Date**_____

**Stamp name or attach card of medical office here ▼**

Back side to be completed by parent/guardian before physical exam.