SAN FRANCISCO WALDORF HIGH SCHOOL

Medical Clearance Form

_____

Student's Last Name (Please Print) First Middle

_____ Incoming Grade (Circle One): 9 10 11 12

Date of Birth

Date of Exam: ____/____/____

Height _____ Weight _____ Pulse _____ BP _____/_____, _____/_____

Vision: R 20/_____ L 20/_____Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	History of Injury/Abnormal Findings	Initials
MEDICAL			
Allergies			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck/Head			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

☐ Cleared for participation in athletics

☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not Cleared. Reason: _____

Name of physician (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of physician: _____ MD or DO