Report of Physical Exam
To be completed by Licensed Physician (M.D.), Physician’s Assistant (P.A.) or Nurse Practitioner (N.P.)

Conserve School requires all newly enrolled students to have a complete physical by a Licensed Physician (M.D.), Physician's Assistant (P.A.) or Nurse Practitioner (N.P.). This exam must have been completed within twelve (12) months prior to the beginning of the semester in which the student will be enrolled at Conserve School.

PHYSICIAN REMINDERS
1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff or dip?
2. Consider reviewing questions on cardiovascular symptoms.
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP /</td>
<td>Respiratory Rate</td>
<td>Pulse</td>
<td>Vision R 20/</td>
</tr>
</tbody>
</table>

MEDICAL

- **NORMAL**
- **ABNORMAL FINDINGS**

**Appearance**
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span>height, hyperlaxity, myopia, MVP, aortic insufficiency)

**Eyes/Ears/Nose/Throat**
- Pupils equal
- Hearing

**Lymph Nodes**

**Heart**
- Murmurs (auscultation standing, supine, +/- Valsalva)
- Location of point of maximal impulse (PMI)

**Pulses**
- Simultaneous femoral and radial pulses

**Lungs**

**Abdomen**

**Genitourinary (males only)**

**Skin**
- HSV, lesions suggestive of MRSA, tinea corporis

**Neurologic**

**MUSCULOSKELETAL**

- **Neck**
- **Back**
- **Shoulder/Arm**
- **Elbow/Forearm**
- **Wrist/Hand/Fingers**
- **Hip/Thigh**
- **Knee**
- **Leg/Ankle**
- **Foot/Toes**
- **Functional**
  - Duck-walk, single leg hop

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\[ ^a \text{Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam} \]

\[ ^b \text{Consider GU exam if in private setting. Having third party present is recommended} \]

\[ ^c \text{Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion} \]

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OVER
The above-named individual is under physician’s care for the following conditions:

Current treatment at time of exam:

Treatment to be continued at Conserve School:

In my opinion, the above-named individual may participate in school activities, without restriction, including but not limited to:

Please check appropriate boxes.

☐ Ability to walk or snowshoe up to five miles per day
☐ Ability to paddle a canoe up to four hours per day
☐ Ability to carry on student’s back a pack weighing up to 25% of their body weight for up to ½ mile
☐ Ability to bike on hard-packed trails at any given point
☐ Ability to sleep on the ground (on a portable sleeping pad) for up to five consecutive nights

Not cleared for school activities including but not limited to those mentioned above:

☐ Pending further evaluation
☐ For any activities
☐ For certain activities  Explanation: __________________________________________________________

I have examined the above-named student and completed the Report of Physical Exam. The student does not present apparent clinical contraindications to participate in the activities listed above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents/guardians. If conditions arise after the student has been cleared for participation in activities at Conserve School, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parents/guardians).

Physician Name (please print):  
Physician’s Signature:  
Date:  

Address  
Phone:  
Fax:  

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