

**PART III -- PHYSICAL EXAMINATION**

NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

\*Tanner Stage or Maturation Index? (males only): \_\_\_\_\_ BP: \_\_\_\_\_

\*Percent Body Fat: \_\_\_\_\_ Pulse: \*(rest) \_\_\_\_\_

\*Audiogram \_\_\_\_\_ \*(Exercise) \_\_\_\_\_

\* Vision: Corrected: (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_ \*(Recovery) \_\_\_\_\_

Uncorrected (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_ \*FEV or Peak Flow (rest) \_\_\_\_\_ \*(Exercise) \_\_\_\_\_ \*(Recovery) \_\_\_\_\_

	N	Abnormal		N	Abnormal
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

**\*WHEN MEDICALLY INDICATED**

(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

**^WITH SPECIAL INDICATIONS**

(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

**I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.**

- CLEARED WITHOUT RESTRICTIONS**
- Cleared **AFTER** further evaluation or treatment for: \_\_\_\_\_
- Cleared for **Limited participation** (check and explain "reason" for all that apply):
  - Not cleared for (specific sports): \_\_\_\_\_
  - Cleared only for (specific sports): \_\_\_\_\_
  - Reason(s): \_\_\_\_\_
- NOT CLEARED FOR PARTICIPATION:** \_\_\_\_\_
- Reason(s): \_\_\_\_\_
- Other Recommendations: \_\_\_\_\_
  - Recommend monitoring during early conditioning because of weight/fitness/other
  - Recommend restrictions or monitoring of weight loss or gain
  - Other: Reasons: \_\_\_\_\_

**MD/DO, PA, NP, DE-SPC#, Signature:** \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print):**

\_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_