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) _______

*(Recovery) _______

*FEV or Peak Flow (rest) _______

*(Exercise) _______

*(Recovery) _______

* Vision: Corrected: (L) _______ (R) _______ (Both)_______

Uncorrected (L) _______ (R) _______ (Both)_______

	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_______