

### PART III - PHYSICAL EXAMINATION

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

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

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

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

\*Audiogram: \_\_\_\_\_ \*(recovery) \_\_\_\_\_

\*FEV or peak flow (rest) \_\_\_\_\_

\*Vision: Corrected (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_ \*(exercise) \_\_\_\_\_  
 Uncorrected (L) \_\_\_\_\_ (R) \_\_\_\_\_ (Both) \_\_\_\_\_ \*(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			^Neuropsych Testing		
Genitalia/hernia (mail 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 close monitoring during early conditioning because of weight/fitness/other
- Recommend restrictions or monitoring of weight loss or gain
- Other: \_\_\_\_\_
- Reason(s): \_\_\_\_\_

Physician Signature: \_\_\_\_\_ +M.D. Date of Examination\*\*: \_\_\_\_\_

Date Signed: \_\_\_\_\_ +(MD, DO, LNP, PA)

Examiner's Name and degree (print): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_