

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Examination (To be completed by the examining physician)

Examination Date: _____

-STUDENT INFORMATION-

Student's Name: _____ Sport: _____
 Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____
 Address: _____
 City/State/Zip: _____ Home Phone: _____
 School: _____ District: _____
 Parent/Guardian's Full Name: _____

-PHYSICIAN INFORMATION-

Name: _____ Phone: _____ Fax: _____
 Address: _____ City/State/Zip: _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Height: _____ Weight: _____ Blood Pressure: _____/_____/_____ Pulse: _____bpm.
 Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

Indicators	Normal? (Circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (incl. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine:	YES	NO	
Range of Motion:	YES	NO	
Scoliosis:	YES	NO	
Upper Extremities:	YES	NO	
Lower Extremities:	YES	NO	
Neurological: Balance & Coordination:	YES	NO	
Romberg:	YES	NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (if yes/possible, please explain)	YES/ Possible	NO	

Most recent immunizations/Dates:
Medications currently being used:
Additional Observations:

General Diagnosis: _____
 Recommendations: _____

CLEARANCES

A. Student MAY participate in the following sports: (CHECK ALL THAT APPLY)

CONTACT/COLLISION NON-CONTACT/STRENUOUS
 LIMITED CONTACT NON-CONTACT/NON-STRENUOUS

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Field Hockey	Baseball	Discus	Bowling
Football	Basketball	Javelin	Golf
Ice Hockey	Cheerleading	Shot put	
Lacrosse	Diving	Rowing	
Soccer	Fencing	Running/Cross Country	
Wrestling	Field	Strength Training	
	High Jump	Swimming	
	Pole vault	Tennis	
	Gymnastics	Track	
	Skiing		
	Softball		
	Volleyball		

B. Student MAY participate in following sport(s) ONLY AFTER completing evaluation/rehabilitation: (CHECK ALL THE APPLY)

CONTACT/COLLISION NON-CONTACT/STRENUOUS
 LIMITED CONTACT NON-CONTACT/NON-STRENUOUS

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

Conditions requiring clearance before sports participation include, but are not limited to: Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

Physician's/Provider's Stamp:

EXAMINED BY:

Family Physician/Provider _____
 School Physician _____

____ MD ____ DO ____ NP ____ PA

Physician's/Provider's Signature: _____ Date: _____

NOTE TO SCHOOL PHYSICIANS: Pursuant to N.J.A.C. 6A:16-2.2, the school physician shall provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this medical report. Please attach this form to the notification letter and ensure that this report is made part of the student's permanent health record.