

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

White

Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

-STUDENT INFORMATION-

Student's Name: _____ Sex: M F Grade: ____ Age: ____ Date of Birth: _____

Address: _____

City/State/Zip: _____ Home Phone #: _____

Sports: _____

School: _____ District: _____

Parent/Guardian's Full Name: _____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here: Name: _____ Phone: _____

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

- FINDINGS OF PHYSICAL EVALUATION -

Height: _____ Weight: _____ Blood Pressure: ____ / ____ Pulse: ____ bpm.

Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
		Squatting makes it: Louder Softer No Change
		Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assess: physical maturation/Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

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General Diagnosis:

General Recommendations:

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

CLEARANCES: This section is completed by the examining healthcare provider.

After examining the student and reviewing the medical history the student is:

- A. Cleared for participation in all sports without restriction.
B. Not cleared for participation in any sport until evaluation and treatment of:
C. Cleared for limited participation in the following types of sports only. Please see below for sport classifications.
Check all that apply CONTACT/COLLISION NON-CONTACT/STRENUOUS LIMITED CONTACT NON-CONTACT/NON-STRENUOUS

Limitations due to:

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following: Anaphylaxis; 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; Seizure Disorder; Marfan Syndrome; 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.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Table with 7 columns: Contact/Collision, Limited Contact, Strenuous, Non-strenuous, and Non-Contact. Rows include Basketball, Ice Hockey, Baseball, Gymnastics, Discus, Strength Training, Bowling, etc.

Table with 3 columns: Effects of physiologic maneuvers on heart sounds, Physical Stigmata of Marfan Syndrome, HCM = Hypertrophic Cardio Myopathy. Rows include Standing, Squatting, Valsalva.

Physician's/Provider's Stamp:

HISTORY REVIEWED AND STUDENT EXAMINED BY:

- Primary Care Provider
School Physician Provider
License Type: MD/DO APN PA

PHYSICIAN'S PROVIDER'S SIGNATURE: Today's Date: Date of Exam:

RESERVED FOR SCHOOL DISTRICT USE

N.J.A.C. 6A:16-2.2 requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation & notification letter is part of the student's school health record.

History and Physical Reviewed By: Date:

Title of Reviewer (please check one): School Nurse School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician: Letter of notification is attached OR

Parent notification indicates that: Participation Approved without limitations Participation Approved with limitations pending evaluation

Participation NOT Approved Reason(s) for Disapproval: