

**FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.  
NIAA PRE-PARTICIPATION PHYSICAL EVALUATION  
(Physical to be completed during an athletes first and third year of participation)**

<b>PHYSICAL EXAMINATION</b>		DATE OF EXAMINATION: _____
NAME: _____		DATE OF BIRTH: _____
HEIGHT: _____	WEIGHT: _____	% BODY FAT (optional): _____ PULSE: _____ BP: ____/____ (____/____, ____/____)
VISION: R 20/ _____	L 20/ _____	CORRECTED: Y / N PUPILS: Equal _____ Unequal _____

<u><b>MEDICAL</b></u>	<b>NORMAL /ABSENT</b>	<b>ABNORMAL FINDINGS</b>	<b>EXPLAIN</b>	<b>INITIALS</b>
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Lungs				
Abdomen				
Genitalia (Males Only)				
Skin				
<b><u>CARDIOVASCULAR</u></b>				
Murmur that Increases From Supine to Standing				
Systolic Murmur Greater Than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
<b><u>MUSCULOSKELETAL</u></b>				
Neck				
Back				
Shoulder / Arm				
Elbow / Forearm				
Wrist / Hand				
Hip / Thigh				
Knee				
Leg / Ankle				
Foot				
Stigmata of Marfan's Syndrome				

**CLEARANCE**

**CLEARED:** \_\_\_\_\_  
Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

\_\_\_\_\_

**NOT CLEARED FOR:** \_\_\_\_\_ **REASON:** \_\_\_\_\_

**Recommendations:** \_\_\_\_\_

\_\_\_\_\_

**Name of physician (print/type):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip Code

\_\_\_\_\_  
**Signature of Health Practitioner** **Date**  
 Approved: February 2000