

**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				
<u><b>CARDIOVASCULAR</b></u>				
Murmur that Increases From Supine to Standing				
Systolic Murmur Greater Than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
<u><b>MUSCULOSKELETAL</b></u>				
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

I, \_\_\_\_\_ hereby certify that I am a licensed \_\_\_\_\_, qualified to perform NIAA Pre-Participation Evaluations, and that on the date set forth below I performed all aspects of the NIAA Pre-Participation Evaluation on the above student. This student meets all physical examination requirements for participation in NIAA sanctioned sports.

\_\_\_\_\_  
**Signature of Health Practitioner**
**License Number**
**Office Phone Number**
**Date**  
 Revised 3-2010