

| Nml | Abn | GENERAL ASSESSMENT | COMMENTS |
|--------------------------|--------------------------|--------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Head | Ht |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes | ----- Actual Wt |
| <input type="checkbox"/> | <input type="checkbox"/> | ENT | ----- Desired Wt |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth/teeth | ----- BP |
| <input type="checkbox"/> | <input type="checkbox"/> | Lungs | ----- P |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdomen | ----- |
| <input type="checkbox"/> | <input type="checkbox"/> | GU | ----- |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin | ----- |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological | ----- |

| Nml | Abn | CARDIOVASCULAR ASSESSMENT | COMMENTS |
|--------------------------|--------------------------|--|-----------|
| <input type="checkbox"/> | <input type="checkbox"/> | BP (sitting) | Peak Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Auscultation (lying and standing) | 1. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pulses | 2. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical signs of Marfan's syndrome (Use screening flow sheet if abn.) | 3. _____ |

| Nml | Abn | MUSCULOSKELETAL EVALUATION | COMMENTS |
|--------------------------|--------------------------|----------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | C-spine | Visual Acuity: |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulders | OD _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbows | OS _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrists | OU _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands | |
| <input type="checkbox"/> | <input type="checkbox"/> | Spine | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hips | |
| <input type="checkbox"/> | <input type="checkbox"/> | Knees | |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankles | |
| <input type="checkbox"/> | <input type="checkbox"/> | Feet | |

ASSESSMENT/PLAN

Obtain Release of Record (specify) _____

Any pre-existing injury/illness?

Medical YES NO _____

Ortho YES NO _____

Waiver Form completed YES NO _____

Cleared

Medical YES NO _____

Ortho YES NO _____

| | |
|--|------------|
| Clinician's Signature _____ | Date _____ |
| Signature of person who performed Musculoskeletal Evaluation if not clinician above _____ | Date _____ |

NAME

NUMBER

BD

Athlete's Pre-participation Physical Exam