

**FORM D -- Health Practitioner, please refer to the letter & references provided on Form C.  
NIAA PRE-PARTICIPATION PHYSICAL EVALUATION**

<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				

<b>CLEARANCE</b>
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**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