TRACK XPLOSION

HEALTH APPRAISAL FORM

To Be Completed By Licensed Medical Provider

ATHLETE INFORMATION

Athlete Name: _____ Date of Birth: _____

Gender: Male Female Age: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Pulse: _____bpm Blood Pressure: _____/_____

Vision: R 20/_____ L 20/_____ Corrected: Yes No Glasses: Yes No Contacts: Yes No

INDICATORS	NORMAL	ABNORMAL	ABNORMAL FINDINGS
Eyes			
Ears/Nose/Throat			
Mouth/Teeth			
Neck/Back/Spine			
Cardiovascular			
Chest/Lungs			
Abdomen			
Skin			
Genitalia-Hernia (male)			
Musculoskeletal: ROM, Strength, Stability			
• Neck			
• Spine (Scoliosis)			
• Shoulders			
• Arms/Hands			
• Hips			
• Thighs			
• Knees			
• Ankles			
• Feet			
Neuromuscular			

Diabetes: Yes No	If yes, Insulin Dependent? Yes No	Non-Insulin Dependent? Yes No

Provide additional comments on abnormal findings: _____

Athlete is: Cleared: _____ Cleared after evaluation for: _____

Not Cleared for: _____ Reason: _____

EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION

Physician Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner in the United States.

Physician's Signature: _____

Printed Name: _____ Date: _____