Adaptive Sports USA Junior Nationals™
Athlete Participation – Sports Physical Exam
(Note: This form is to be completed by a Physician, Physician Assistant, or Nurse Practitioner)

Athlete Name: ______________________________ Date of Birth:______________ Gender: ☐Male ☐Female

Street Address: ____

City:____________________State:______________ Zip Code:___________ Contact phone:_______________

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER

Disability Diagnosis: ____

Height:___________ Weight:____________ Pulse:_____________ Blood Pressure:_____________

Region Examined	Satisfactory? Yes	No	Comments
Eyes	☐	☐	
Ears, Nose, Throat	☐	☐	
Mouth & Teeth	☐	☐	
Cardiovascular	☐	☐	
Chest & Lungs	☐	☐	
Abdomen	☐	☐	
Skin	☐	☐	
Muskuloskeletal: ROM, strength, etc.	☐	☐	

Follow-up recommendations:____

Sports Participation approved: ☐ Yes ☐ No Restrictions____

Please Print/ Stamp

Physician's Name____ Telephone_______________________

Street Address __________________________________City, State, Zip Code ___________________________

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. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature ____ Date _______________