Form 10
2017 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/Age**: _____ **Sex**: _____

Address: _____

Sport(s): _____ **Disability**: _____

Family Physician: _____ **Phone**: _____

Height: _____ **Weight**: _____ **BP**: _____

General:

Region Examined	Satisfactory Yes	No	Not Examined	Comments
Eyes	☐	☐	☐	
ENT	☐	☐	☐	
Dental	☐	☐	☐	
Chest	☐	☐	☐	
Heart	☐	☐	☐	
Abdomen	☐	☐	☐	
Genitalia	☐	☐	☐	
Skin	☐	☐	☐	
Ortho	☐	☐	☐	
Neuro	☐	☐	☐	
Flexibility/Strength	☐	☐	☐	

Follow-up recommendations: _____

Sports Participation approved: ☐ **Yes** ☐ **No** **Restricted** _____

Limitations: _____

Physician's Signature: _____ **Date:** _____