BRIAR CLIFF UNIVERSITY ATHLETICS PRE-PARTICIPATION EVALUATION

NAME: _____ DATE OF BIRTH: _____

DATE OF EXAM: _____ SPORT(S): _____

PHYSICAL EXAMINATION *(To be completed by an MD, DO, PA, or NP. Physicals completed by any other medical provider will **not** be accepted.)*

Height (ft/in): Weight (lbs): Sex: ☐ Male ☐ Female

BP: (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N

Allergies:

Medical Alerts:

List of current medications:

	NORMAL	ABNORMAL FINDINGS *(please explain)*
Eyes/ears/nose/throat		
Cardiovascular [a]		
Respiratory		
Gastrointestinal/Abdomen		
Genitourinary [b]		
Endocrine/Metabolic		
Neurological [c]		
Skin		
Musculoskeletal		
Mental/Emotional Status		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

ATHLETIC PARTICIPATION ELIGIBILITY (*To be completed by the medical provider that completed the pre-participation exam*)

☐ Cleared for all sports without restrictions

☐ Not cleared *(please provide further details below)*:

- ☐ Pending further evaluation
- ☐ For certain sports
- ☐ For any sports

Reason(s)/recommendations regarding athletic participation eligibility status: _____

** I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice andparticipate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the patient/student athlete. If conditions arise after the athlete has been cleared for participation, the medical provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).*

Name of medical provider (print): _____ Date: _____

Address: _____ Phone: _____

Signature of medical provider: _____ MD, DO, PA, or NP (please circle one)