

**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: \_\_\_\_\_

**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: \_\_\_\_\_