Athlete's Name: _____

THIS PAGE TO BE COMPLETED BY MEDICAL EXAMINER ONLY

MEDICAL PHYSICAL INFORMATION

Height	Weight	Temperature	Pulse	O_2Sat	Blood Pressure		Vision
in	lbs	F			BP Right	BP Left	**Right Vision** ☐ No ☐ Yes ☐ N/A 20/40 or better **Left Vision** ☐ No ☐ Yes ☐ N/A 20/40 or better

Right Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		Bowel Sounds	☐ Yes	☐ No	
Left Hearing (Finger Rub)	☐ Responds	☐ No Response	☐ Can't Evaluate		Hepatomegaly	☐ No	☐ Yes	
Right Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		Splenomegaly	☐ No	☐ Yes	
Left Ear Canal	☐ Clear	☐ Cerumen	☐ Foreign Body		Abdominal Tenderness	☐ No	☐ RUQ ☐ RLQ	☐ LUQ ☐ LLQ
Right Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	Kidney Tenderness	☐ No	☐ Right ☐ Left	
Left Tympanic Membrane	☐ Clear	☐ Perforation	☐ Infection	☐ NA	Right upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia
Oral Hygiene	☐ Good	☐ Fair	☐ Poor		Left upper extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia
Thyroid Enlargement	☐ No	☐ Yes			Right lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia
Lymph Node Enlargement	☐ No	☐ Yes			Left lower extremity reflex	☐ Normal	☐ Diminished	☐ Hyperreflexia
Heart Murmur (supine)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		Abnormal Gait	☐ No	☐ Yes, describe _____	
Heart Murmur (upright)	☐ No	☐ 1/6 or 2/6	☐ 3/6 or greater		Spasticity	☐ No	☐ Yes, describe _____	
Heart Rhythm	☐ Regular	☐ Irregular			Tremor	☐ No	☐ Yes, describe _____	
Lungs	☐ Clear	☐ Not clear			Neck & Back Mobility	☐ Full	☐ Not full, describe _____	
Right Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+		Upper Extremity Mobility	☐ Full	☐ Not full, describe _____	
Left Leg Edema	☐ No	☐ 1+ ☐ 2+	☐ 3+ ☐ 4+		Lower Extremity Mobility	☐ Full	☐ Not full, describe _____	
Radial Pulse Symmetry	☐ Yes	☐ R>L	☐ L>R		Upper Extremity Strength	☐ Full	☐ Not full, describe _____	
Cyanosis	☐ No	☐ Yes, describe _____			Lower Extremity Strength	☐ Full	☐ Not full, describe _____	
Clubbing	☐ No	☐ Yes, describe _____			Loss of Sensitivity	☐ No	☐ Yes, describe _____	

☐ **Athlete does not have any neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability.**

☐ **Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and therefore must receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.**

RECOMMENDATIONS *(TO BE COMPLETED BY EXAMINER ONLY)*

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete is deemed to need further medical evaluation please utilize the Rock'n Our Disabilities Further Medical Evaluation Form, page 2 order to provide the athlete with medical clearance.

☐ This athlete is **ABLE** to participate in Rock'n Our Disabilities Foundation sports. (Use Additional Licensed Examiner Notes for any restrictions or limitations).

☐ This athlete **MAY NOT** participate in Rock'n Our Disabilities Foundation sports at this time and must be evaluated by a physician for the following concerns:

☐ Concerning Cardiac Exam ☐ Acute Infection ☐ O_2 Saturation Less than 90% on Room Air

☐ Concerning Neurological Exam ☐ Stage II Hypertension or Greater ☐ Hepatomegaly or Splenomegaly

Other, please describe: _____

☐ **Additional Licensed Examiner's Notes:**

☐ Follow up with a cardiologist ☐ Follow up with a neurologist ☐ Follow up with a primary care physician

☐ Follow up with a vision specialist ☐ Follow up with a hearing specialist ☐ Follow up with a dentist or dental hygienist

☐ Follow up with a podiatrist ☐ Follow up with a physical therapist ☐ Follow up with a nutritionist

☐ Other: _____

Name: _____

E-mail: _____

Licensed Medical Examiner's Signature _____ Date of Exam _____ Phone: _____ License: _____

FURTHER MEDICAL EVALUATION FORM

(Only to be used if the athlete has previously not been cleared for sports participation above)

Examiner's Name:		**Examiner's Name:**	
Specialty:		**Specialty:**	

I have examined this athlete for the following medical concern(s):
Please describe

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete:

☐ Yes ☐ No May participate in Rock'n Our Disabilities sports (see below for restrictions or limitations)

☐ Additional Examiner Notes:

In my professional opinion, this athlete:

☐ Yes ☐ No May participate i n Rock'n Our Disabilities sports (see below for restrictions or limitations)

☐ Additional Examiner Notes:

E-mail:		E-mail:	
Phone:		Phone:	
License:		License:	

Examiner's Signature Date

Examiner's Signature Date