



Scholarship / Invited Walk-On (has athletic deferment form)

Walk-On

Sport \_\_\_\_\_

Florida State University

1<sup>st</sup> Year of Participation Athletic Physical

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

FSU Health Services ID# \_\_\_\_\_

Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Height (inches) \_\_\_\_\_ Weight (lbs) \_\_\_\_\_

BP \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ LMP \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_  Corrected  Uncorrected

**IMMUNIZATIONS**

_____ Td	_____ Tdap	_____ MMR #1	_____ MMR #2
_____ Hep B #1	_____ Hep B #2	_____ Hep B #3	
_____ Meningitis #1	_____ Meningitis #2	_____ PPD (Clinician Request)	

**PHYSICAL EXAM**

	<u>CHECK ONE</u>	<u>EXPLAIN IF ABNORMAL</u>
1. General	____ Normal ____ Abnormal	_____
2. Head and Neck	____ Normal ____ Abnormal	_____
3. Eyes, Ears, Nose, Throat	____ Normal ____ Abnormal	_____
4. Teeth and Mouth	____ Normal ____ Abnormal	_____
5. Lungs and Chest	____ Normal ____ Abnormal	_____
6. Cardiovascular	____ Normal ____ Abnormal	_____
7. Abdomen	____ Normal ____ Abnormal	_____
8. Lymphatic	____ Normal ____ Abnormal	_____
9. Genitalia/Hernia	____ Normal ____ Abnormal	_____
10. Skin	____ Normal ____ Abnormal	_____
11. Spine / Extremities	____ Normal ____ Abnormal	_____

Hemogram	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Pending	Recommendation _____
Sickle Cell	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	<input type="checkbox"/> Pending	
Ferritin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Pending	<input type="checkbox"/> N/A
Vitamin D	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Pending	<input type="checkbox"/> N/A
Additional Testing: _____				
EKG - Preliminary: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Pending Overread _____				
(Computer EKG Interpretation)				

Pending studies and / or indicated limitations will be reviewed by the Athletic Department physician. Based upon the medical history and my limited examination, I am of the opinion that this athlete:

- MAY** participate in all activity beginning today.
- MAY** participate in **LIMITED** activity. Explain \_\_\_\_\_
- MAY NOT** participate in any activity until the following pending results or the evaluation of the indicated medical condition are completed and reviewed by the Athletic Department physician. Explain \_\_\_\_\_

\_\_\_\_\_  
Date Signature of Clinician Stamp / Print Clinician Name License Number & State

**PENDING RESULTS RECEIVED**

EKG Read	<input type="checkbox"/> Normal for Athlete	<input type="checkbox"/> Abnormal
Sickle Cell	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive, (Hemoglobin Electrophoresis Date & Result _____)
Ferritin	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Vitamin D	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

Follow Up Required \_\_\_\_\_  
\_\_\_\_\_  
Date Signature



Florida State University
Athletic Department Preparticipation Medical History

Scholarship / Invited Walk-On (has athletic deferment form) Walk-On FSU Health Services ID#

Name Sport Date

Date of Birth Cell Phone Number Male Female

Year of Athletic Participation at FSU: 1st 2nd 3rd 4th 5th Female Athletes - 1st day of last menstrual period

Table with 3 columns: Y, N, General Medical History (43 questions), and If yes, please explain.

Additional Explanations

I certify that the answers to the questions above are true and correct. Athlete's Signature Date

Comments by Clinician
Clinician Signature Stamp / Print Clinician Name License # and State Date