BASCS AD Form #10

PHYSICIAN PLEASE FILL OUT, SIGN AND DATE THIS SIDE

Name _____ D.O.B._____

Height_____ Weight_____ B/P_____ BMI_____
Vision Corrected R _____ Uncorrected R _____
Corrected L _____ Uncorrected L _____

TO BE FILLED OUT BY A PHYSICIAN OR NURSE PRACTITIONER ONLY:

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Skin			**Musculosketal**		
Head			**Spine/Scoliosis Hips/Thighs/ Knees**		
Eyes/Ears			**Ankle/Feet**		
Nose/Throat					
Lymphadenopathy			**Neurological**		
Chest/Lungs			**Endocrine**		
Cardiovascular			**Genito Urinary**		
Abdominal					

EXPLAIN
ABNORMALS:_____
_____

Student Maturity Rate: _____

I have examined this student and certify that he/she is physically qualified to participate in the following categories of competition:

Check all areas approved, any unmarked categories indicate disqualification.

CONTACT/COLLISION ___ LIMITED CONTACT/IMPACT ___

STRENUOUS/NON CONTACT ___ NON STRENUOUS/ NON CONTACT ___

PLEASE PLACE A CHECK IN THE BLANK BELOW FOR WORKING PAPERS

____ is able to fulfill duties of being employed

Reason for disqualification: _____

Date of Exam: _____ PHYSICIAN: _____

_____ _____ _____
Print Physicians Name Address Phone #