



**PHYSICIAN'S FITNESS VERIFICATION**

To be completed by Physician, Physician Assistant, or Nurse Practitioner. This form is valid up to 12 months after a routine physical. A physical must be performed and a new form must be turned in if this form goes out of date – AJRA must have a current form on hand at all times.

**Note to Physician:** Participation in the AJRA Rowing Program will require the athlete to practice outdoors 6 days a week for 2 ½ hours per day in all weather conditions. Muscular and cardiovascular endurance is required for this competitive sport.

**This form must be used; immunization form or school sports clearance form does not serve as physician's opinion of fitness for participation in Rowing.**

Athlete's Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

|    |           | Normal | Abnormal |             | Normal | Abnormal |
|----|-----------|--------|----------|-------------|--------|----------|
| 1. | ENT, Eyes | _____  | _____    | 6. Hernia   | _____  | _____    |
| 2. | Neck      | _____  | _____    | 7. GU Spine | _____  | _____    |
| 3. | Heart     | _____  | _____    | 8. Spine    | _____  | _____    |
| 4. | Lungs     | _____  | _____    | 9. Joints   | _____  | _____    |
| 5. | Abdomen   | _____  | _____    |             |        |          |

NOTES: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_ (Date must be within the last 10 years)

Date of Physical Examination: \_\_\_\_\_

Describe any previous injuries or additional conditions that may affect this athlete's performance or treatment. \_\_\_\_\_

**FITNESS SUMMARY AND REVIEW**

Clear, unrestricted \_\_\_\_\_ Not cleared, further evaluation needed \_\_\_\_\_

On the basis of the above limited examination, together with the medical history furnished to me by the parent or guardian, I have found no indications of physical or medical reason which would make it inadvisable for the above named person to engage in rowing and all related activities with the Atlanta Junior Rowing Association, except as indicated above.

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Healthcare Provider Name: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_