



Due 8/15

PHYSICAL EXAMINATION
To be completed by a physician

Name _____ Date of Birth _____ / _____ / _____ Sex _____ Grade _____
(Last) (First) (Initial) (Mo) (Da) (Yr)

Dates of most recent: Td _____ Tdap _____ Measles Vac. _____ TB Skin _____ Urine Test _____ Hbg _____
Height _____ Weight _____ BP _____ Hearing R _____ L _____

Vision (w/o glasses) R 20/ _____ L 20/ _____ (with glasses) R 20/ _____ L 20/ _____ Color Vision _____

Allergies (e.g., hay fever, adhesive tape, insect stings, drugs) _____

Could this student require emergency action while at school (e.g., seizure, insect stings, allergy, bleeding problems, diabetes, heart problem)? _____ If YES, please describe _____

Any current medical problems (e.g., exercise-induced asthma)? _____ If YES, please describe _____

SYSTEMS EXAMINED

	Examined	Comments
Appearance, nutrition, skin		
Posture, gait, spine (Scoliosis)		
Ears, nose, throat, eyes		
Neck, heart, lungs		
Abdomen, genitalia		
Bones, joints, muscles		
Neurological		

DEVELOPMENTAL SCREENING

Gross and fine motor		
Adaptive, social, language		

Any limitation of physical activities (e.g., running /contact sports)? Yes _____ No _____
(Specify) _____

Any known orthopedic injury or condition? Yes _____ No _____
(Specify) _____

Is this student capable of unlimited participation in the athletic program? _____ Yes _____ No

If NO specify _____

SIGNED _____ DATE _____
Examining Physician