PHYSICAL EXAMINATION - **TO BE COMPLETED BY PHYSICIAN OR LICENSED HEALTHCARE PROVIDER**

Name:		○ Male ○ Female	Date of Birth:
EXAMINATION			
Height:		Weight:	
BP: /	Pulse:	Vision: R 20/ L 20/	Corrected: Yes No

MEDICAL	NORMAL	ABNORMAL FINDINGS
Physical Appearance		
Eyes, ears, nose, throat -glasses/contacts -cochlear implant		
Neck		
Heart -congenital defect, murmur		
Lungs		
Abdomen		
Genitourinary		
Skin -Eczema, contact dermatitis, HSV, MRSA, tinea corporis		
Neurologic -Reflexes, hx seizures, frequent headaches or migraines		
MUSCULOSKELETAL		
Head to Toe -Scoliosis/Kyphosis		

CHRONIC CONDITIONS

Attach relevant action plans

ROUTINE MEDICATIONS

MENTAL HEALTH

SURGICAL HISTORY

Other Pertinent Medical Information

IMMUNIZATIONS ***ALL NEW STUDENTS MUST SUBMIT A COPY OF IMMUNIZATION RECORD***
RETURNING STUDENTS NEED ONLY SUBMIT A RECORD OF RECENT IMMUNIZATIONS

○ Cleared for full participation in PE ○ Cleared for all sports without restrictions

○ Cleared for PE and all sports with the following restrictions

-please specify:

○ NOT cleared: ○ for any sport/PE ○ pending further evaluation ○ For specific sport(s)-list: _____

Name of Physician (please print) : _____

Address:_____

_____

Signature of Physician: _____ Date: _____