

STUDENT PHYSICAL EXAMINATION

Student's full name _____ SSN _____
 Address _____ DOB _____
 Name of parent/guardian _____ ALLERGIES _____

A. HEALTH EXAMINATION Height _____ Weight _____ BP _____

N=Normal A=Abnormal	N	A	COMMENT: abnormal findings, by number
1. General Appearance			
2. Skin			
3. Head / Scalp			
4. Eyes			
5. Visual acuity (R & L)			
6. Ears			
7. Auditory acuity			
8. Nose / Throat			
9. Mouth, teeth, gums			
10. Chest / lungs			
11. Heart			
12. Abdomen			
13. Genitalia			
14. Musculoskeletal			
15. Neurological			
16. Alertness			
17. Emotional / mental Behavior problems			
18 Abuse, substance / physical/emotional			
19. Nutrition			

B. HEALTH HISTORY (serious illness, injuries, medical conditions requiring daily medications)

C. SPORT or ACTIVITY RESTRICTIONS (circle one) NONE YES – specify limitations

D. IMMUNIZATIONS

Current Tetanus	YES	NO
Hepatitis B series complete	YES	NO
Vaccine record current	YES	NO

Physician's Name (print) _____
 Clinic Address: _____

PHYSICIAN'S Signature _____ Date _____