



PHYSICAL EXAMINATION FORM (To be filled out and signed by examining physician)

PATIENT INFORMATION Please print clearly

First Name: _____ Last Name: _____

DOB: _____ Grade: _____

Height: _____ Weight: _____ Eyes R:20/ _____ L:20/ _____ With
Without correctives

Ears: Right _____ Left _____

Nose/Throat _____ Teeth/Dentures _____ Skin _____

Heart _____ Lungs _____ BP (rt arm sitting) _____

Abdomen _____ Hernia _____ Pulse rest _____

Spine/Neck _____ Shoulders/Elbows/Hands _____

Hip/Knee _____ Ankle/Feet _____

Genitalia _____ Lymphatics _____

Laboratory: Urinalysis (dipstick)

Albumin _____ Sugar _____ Blood _____

Other lab tests: Only if specifically indicated or required

Urinalysis: Sp. Gr. _____ React. _____

Hemoglobin/Het _____

Tuberculin: Pos _____ Neg _____

Other _____

I certify that I have on this date examined the above student and I have found no medical reason to disqualify him/her from participating in all supervised athletics and physical education activities with the exception of:

Name of Physician _____ MD _____ DO _____

Signature of Examining Physician _____ Date _____