PHYSICAL EXAMINATION FORM FOR STUDENTS

Student's Name: _____ Student ID #_____
Grade: _____ Birth Date: _____ Sex: _____
Parents/Guardians Names: _____ _____
Address: _____

_____

Medical history to include: rheumatic fever, tuberculosis, epilepsy, allergies, operations, serious illnesses, congenital defects and menstrual disturbances:

Has your son/daughter had a concussion? ☐ Yes ☐ No

If so, how many? _____ Date of Last concussion _____

Immunization Recommendations: _____

Physical Examination	**Check**			**Additional Remarks**
Normal, Abnormal, Not Examined	N	A	NE	
General Weight & Nutrition				
General Appearance				
Skin (Acne, Tinea, Dermatitis)				
Eyes (Conjunctivae, Cornea, EOM)				
Ears (Perforations, Deafness)				
Nose (Allergy, Deformities)				
Teeth (Cavities, Gingivitis, Occlusion)				
Tonsils				
Lymph Nodes				
Chest (Deformities)				
Lungs				
Heart (Size, Murmur, Rhythm)				
Breast				
Abdomen				
Hernias				
Genitalia				
Back (Kyphosis, Lordosis, Scoliosis)				
Skelton (Limited Motion, Deformities)				
Feet (Flat, Pronated, Tinea)				

Blood Pressure _____ Ht._____Wt._____

_____

This student may participate in:

Competitive Sports Yes_____ No_____
Regular Physical Education Yes_____ No_____
Limited P.E. Only Yes_____ Duration_____

_____ _____
Physician's Signature Date

_____ _____
Type or print physician's name License Number

PHYSICALS FROM A CHIROPRACTOR ARE NOT VALID FOR ATHLETIC CLEARANCE

Sign and Return