

# PHYSICAL EXAMINATION

(To be completed and signed by MD, NP, or PA) Required by August 1

Student name \_\_\_\_\_ Date of Physical \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_

	Norm.	Abn.	N.E.	Comments
Head				
Eyes				
ENT				
Teeth				
Neck (incl. thyroid)				
Chest and lungs				
Heart				
Abdomen				
Genitalia (incl. hernia)				
Pelvic (if indicated)				
Rectal (if indicated)				
Spine				
Extremities and joints				
Neurologic				
Skin				
Emotional status				

Is the student free from communicable disease?    Y    or    N

Drug Sensitivity? If so, what? \_\_\_\_\_

Is the patient now under treatment for any medical or emotional condition?    Y    or    N

If yes, what? \_\_\_\_\_

Are you aware of any other pertinent information pertaining to this student's health that has not been addressed in the history and physical?

Y    or    N    If yes, what? \_\_\_\_\_

**Is this student capable of participating in a full program of physical activity, including competitive athletics?**

Y    or    N    Limitations, if any? \_\_\_\_\_

Impression(s) \_\_\_\_\_

Recommendations \_\_\_\_\_

MD, NP, or PA signature \_\_\_\_\_ Physician's phone \_\_\_\_\_

**This completed form must be submitted as directed, regardless of anticipated participation in athletics.**