



## PHYSICAL EXAMINATION BY PHYSICIAN

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Pulse: \_\_\_\_\_ Resp.: \_\_\_\_\_ Hearing: \_\_\_\_\_ Scoliosis: \_\_\_\_\_

Visual Activity: R \_\_\_\_\_ L \_\_\_\_\_

Other Helpful Medical Information:

### COMMENTS, OBSERVATIONS, RECOMMENDATIONS:

Medication currently taken: \_\_\_\_\_

Allergies (medication, environmental, etc.) \_\_\_\_\_

Allergic response: \_\_\_\_\_ Treatment: \_\_\_\_\_

Any concerns: \_\_\_\_\_

Is he/she able to participate in all school activities? \_\_\_\_\_

Is he/she able to participate in physical education and sports programs? \_\_\_\_\_

If not, please enclose a separate explanation with support guidelines.

Physician's Signature: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Physician's phone: \_\_\_\_\_

Physician's Name (printed): \_\_\_\_\_

Physician's Address: \_\_\_\_\_

PLEASE INCLUDE ANY RECORDS AND/OR SUMMARIES PERTINENT TO MEDICAL PRESCRIPTIONS.