



PHYSICAL EXAMINATION FORM

NAME _____ **DATE OF BIRTH** _____

Height _____ **Weight** _____ **Blood Pressure** _____

Scoliosis/Spinal Deformity (Yes or No)? _____

Vision: **Right** _____ **Left** _____ **(No Glasses)**
 Right _____ **Left** _____ **(With Glasses)**

Hearing: **Right** _____ **Left** _____

TB Test: **Date** _____ **Reaction** _____

Last Tetanus shot (date): _____

Please answer the following questions based on your examination:

1. Is this student in good health and free of communicable diseases or physical/emotional conditions which might impede school performance? _____
2. Did you find this student to be physically qualified to participate in all supervised sports? _____
3. Does this student have a health condition which may require emergency action while at school? (Please specify condition and recommendations.) _____
4. Is this student on any long-term medication? (Please specify drug and diagnosis.) _____
5. Does this student have any allergies that the school should be aware of? _____
6. Can this student, with parental permission, take Advil, Tylenol, Sudafed or Benadryl at school? _____
7. Does the student have any special health needs which require modification of the school program? (Please specify needs and recommendations.) _____

This is to certify that a complete physical examination has been performed by me.

Name _____ **Date of Exam:** _____

Address _____

Physician's Signature: _____ **Phone Number:** _____