PHYSICAL EXAMINATION REPORT

Date: _____

Name: _____ _____ _____
Last First Middle I.

Address: _____

Phone: (___)_____-_____ Sex: _____ Age: _____ Grade: ____ Birthdate: _____

Emergency Contact Person: _____

Phone: (___)_____-_____

Family Doctor: _____ Phone: (___)_____-_____

*** DO NOT WRITE BELOW THIS LINE ***

Code: 0 = Satisfactory
X = Unsatisfactory

Height: _____ Weight: _____

Blood Pressure: _____ Pulse: _____

Eyes: _____ Heart: _____ Vision: R - Corrected _____
Ears: _____ Lungs: _____ L - Corrected _____
Nose: _____ Abdomen: _____ R - Uncorrected _____
Throat: _____ Scoliosis: _____ L - Uncorrected _____
Lymph: _____ Extremities: _____ Glasses _____
Skin: _____ Hernia: _____ Contact Lenses: R - _____ L - ____ Both- _____
Urinalysis: Sug. _____ AIb. _____
Leuck. _____ Blood _____ Menses? Y or N

Does this person regularly take any medication? If so, Please explain.

_____

Does this person have any known allergies? _____

The above name individual has been cleared for participation in the following activities:

_____

_____ Limited contact impact (Basketball, Volleyball)

Provider's/Physician's Signature: _____

Physician's Name: _____ Date: _____
Please print