PHYSICAL EXAMINATION FORM FOR STUDENTS

Name:____UID#__________________

Grade:_______School Site:____________________________Birth Date: ___________________

Father: ________________________________ Mother: ______________________________

Address:____

Parent Consent: ____

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: ______________ Height:________________ Weight: ___________

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