



Physical Examination Form



(To be completed by a physician or a U.S. licensed nurse practitioner or a physician's assistant)

I. STUDENT INFORMATION

Name of student: _____ Grade: _____

Date of Birth: _____ Date of Exam: _____ Height: _____ Weight: _____

Blood Pressure: _____ Pulse: _____ TB Status Mantoux or Chest X-ray results: _____

OR Date BCG: _____ Blood Type: _____ Rh Factor: _____

Vision: R _____ L _____ With glasses or contacts R _____ L _____ (Normal/Referred)

Please attach Hearing tests results (if any)

EXAMINATION:

Clinical Exam	Normal	Significant History, or Abnormal Exam (please explain)
1. Skin		
2. Head and Neck		
3. Eyes		
4. Ears, Nose, Mouth		
5. Cardiovascular		
6. Respiratory (asthma, other)		
7. Abdomen		
8. Musculoskeletal (see below)		
a) Shoulder/Clavicle		
b) Arm/elbow/wrist/hand		
c) Back (Check also for Scoliosis)		
d) Hip/Pelvis		
e) Thigh/Knee		
f) Lower leg/ankle/foot		
9. Neurological		
10. Emotional/Mental Status		
11. Nutritional Status		
12. Developmental Status		
13. Surgery or Serious Illness in past		
14. Other Significant Observations/History		
ALLERGIES OF ANY KIND insect, food, environmental (list medication of choice)		

Summary of current health condition, medications and therapies:



Students may choose to participate in competitive interscholastic sports program. Among these may be basketball, soccer, swimming, tennis but not limited to these alone.

_____ I hereby certify that this student was examined by me, with particular attention to those systems affected by strenuous physical activity. No physical condition was detected that would reasonably be anticipated to render this student /athlete physically unfit to engage in sport activities.

_____ I have examined this student and find him/her fit to participate in sports with the following exceptions or precautions. _____

_____ I do not recommend this student to participate in competitive sports because: _____

Name of physician: _____

Address: _____

Signature: _____ **Date:** _____

STUDENT/ATHLETIC EMERGENCY MEDICAL PERMISSION:

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examination, and immunizations for my child. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If it is not possible to contact me, the treatment necessary for the best interest of my child may be given.

Permission is also granted to the teacher, coach or chaperone to provide the needed emergency treatment prior to the student's admission to medical facilities.

Father's Signature: _____ **Mother's Signature:** _____

Date: _____ **Emergency contact numbers:** _____