

**PHYSICAL EXAM FORM TO BE COMPLETED BY PHYSICIAN**

**STUDENT'S NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_  
Vision: R \_\_\_\_\_ L \_\_\_\_\_ (with/without glasses) Contacts \_\_\_\_\_  
Hearing: R \_\_\_\_\_ L \_\_\_\_\_ Scoliosis Screening \_\_\_\_\_

PHYSICAL EXAM: WNL \_\_\_\_\_  
If any abnormal findings please describe \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

Asthma: Pattern of occurrence \_\_\_\_\_  
Peak flow \_\_\_\_\_ Medications \_\_\_\_\_

Current medical problems \_\_\_\_\_  
Significant past illnesses \_\_\_\_\_

**IMMUNIZATIONS:** Please list all dates

|                      |                            |
|----------------------|----------------------------|
| DPT,DT _____         | TETANUS _____              |
| MMR _____            | MEASLES _____              |
| POLIO _____          | MUMPS _____                |
| HIB _____            | RUBELLA _____              |
| PPD _____            | CHICKENPOX – DISEASE _____ |
| HEPATITIS B 1) _____ | 2) _____ 3) _____          |
|                      | VARICELLA VACCINE _____    |
|                      | OTHER _____                |

Activity full \_\_\_\_\_ Activity limited (explain) \_\_\_\_\_

I HAVE EXAMINED THIS STUDENT AND HAVE FOUND HER PHYSICALLY FIT TO PARTICIPATE IN PHYSICAL EDUCATION/SPORTS. THE STUDENT MAY BE GIVEN THE NON-PRESCRIPTION MEDICATIONS AS NEEDED INDICATED BY THE PARENTS ON THE FRONT OF THIS FORM.

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

(Physician's Stamp)