Physical Examination Form

Name:_____ Perm ID #: _____ Physical Date: _____

Date of Birth:_____Sex: M____F____ Grade: _____ School: _____

Parent's /Guardian's Name _____ Phone: _____

Sports:_____

Current Medications: _____

Medical History: Do you have or have you had any of the following conditions:

1. Allergy to any medication?	Yes	No	6. Knocked out or bad head injury?	Yes	No
2. Asthma?	Yes	No	7. Surgical procedures?	Yes	No
3. Seizure disorder?	Yes	No	8. Allergy to bee stings?	Yes	No
4. Joint or muscle pain?	Yes	No	9. Last tetanus Shot? Date: _____		
5. Vision or hearing problems?	Yes	No	10. Other medical conditions?	Yes	No

If yes, please explain: _____

Has any blood relative ever had?

Cancer:	Yes_____	No____	Stroke:	Yes _____	No____
Tuberculosis	Yes _____	No____	Epilepsy:	Yes _____	No____
Diabetes	Yes _____	No____	Mental illness	Yes _____	No____
Heart trouble	Yes_____	No____	Suicide	Yes _____	No____
High blood pressure	Yes _____	No _____	Congenital deformities	Yes _____	No _____

Physical Examination

Height _____ Weight _____ Blood Pressure _____
Pulse_____ Pulse after Exercise _____
Physical appearance_____Nose and throat_____Hernia and genitals _____
Skin _____ Glands_____Ears _____ Heart _____
Eyes _____ Lungs _____ Urinalysis _____
Mouth and teeth_____ Posture & extremities _____
Other:_____

This student is cleared for school sports: Yes No

Recommendations or restrictions: _____

_____ _____
Please print name of Medical Examiner Signature of Medical Examiner

Phone #: _____

Office Stamp Please ➡ ➡ ➡