SCHOOL PHYSICAL EXAMINATION

Name ____ Exam Date ____ Age ____ Date of Birth ____
Address ____ City/State/Zip ____ Home Phone ____
School ____ Sport ____ Grade ____ Sex ____
Physician ____ Phone ____ Fax ____
Address ____ City/State/Zip ____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Height:____________ Weight:___________ Blood pressure: ____/____ Pulse: ______bpm
Vision: R20/___L20/___ Corrected: Y/N Contacts: Y/N Glasses: Y/N

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears/Hearing			
Nose/Mouth/Throat			
Heart: Murmurs/Elhythms			
Lungs: Auscultation/Percussion			
Chest Contour			
Skin			
Abdomen: Assessment (inc. Liver, Spleen)			
Tanner Stage: Testes/onset of menses			
Hernia	No	Yes/Possible	
Neck/Back/Spine: Range of motion			
Scoliosis			
Upper Extremities			
Lower Extremities			
Neurological: Balance & Coordination			
Romberg			
Heel Walk			
Tandem Walk			
Nose Touch			
Toe Walk			

Most recent immunization dates: ____
Medications currently in use: ____
Allergies: ____
Operations or accidents: ____

A. Student may participate in athletics: Yes ___ No ___ Date _________
B. Cleared after completing evaluation/rehabilitation for:_______________________________
C. NOT CLEARED FOR: Collision ___ Contact ___ Non-contact ____
Strenuous ___ Moderate ___ Non-strenuous ___

Diagnosis: ____
Recommendations: ____

Examined by: Family Physician/Provider ___ School Physician ___
__MD __ DO __NP __PA

Physician/Provider Signature: ________________________________

Physician's/Provider's Stamp

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