



Fremont Union High School District

Physical Exam Form - Part 2

Physical Examination Form (Required)

A doctor must administer this Physical Exam & sign/date below.

Student ID# _____

Parents - Please complete the top line for the doctor and please print neatly. All other areas will be completed by the doctor.

Last Name: First Name: M.I.: DOB School:

Height: Weight: % Body Fat (optional) Pulse: BP: (___ / ___ , ___ / ___)

Vision: R - 20/ L - 20/ Corrected: Y N Pupils: Equal _____ Unequal _____

Follow-up Questions on More Sensitive Issues - Questions asked by the doctor	Yes	No
1. Do you feel stressed out or under a lot of pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel safe?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever tried cigarette smoking, even 1 or 2 puffs?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past 30 days, have you used chewing tobacco, snuff, or dip?	<input type="checkbox"/>	<input type="checkbox"/>
7. During the past 30 days, have you had at least one drink of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever taken steroid pills or shots without a doctor's prescription?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever taken any supplements to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>
Does this student:		
10. Wear eyeglasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
11. Wear dental bridges, braces, or plates?	<input type="checkbox"/>	<input type="checkbox"/>
12. Take any medications? If so, please list them below.	<input type="checkbox"/>	<input type="checkbox"/>

Dr.'s Notes:

DOCTOR'S EXAMINATION	NORMAL	ABNORMAL FINDINGS (Doctor, please list & describe any abnormalities)
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph Nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hips/thigh		
Knee		
Leg/ankle		
Foot/toes		

Multiple-examiner set-up only. **Having a third party present is recommended for the genitourinary examination.

DOCTOR'S CLEARANCE: This student is medically cleared to participate in sports/activities: YES ___ NO ___ (Doctor checks one)

Exceptions or limitations (if any):

Doctor's Printed Name & Address:
(Stamp is okay)

Doctor's Signature: _____ Date: _____

M.D.? Yes No Doctor's I.D. #: _____