PHYSICAL EXAM 2024-2025
Healthcare Provider to Complete

The Wellness Center will NOT ACCEPT a physical exam performed by a healthcare provider who is also the student's parent.

Student Name:_____ Date of Birth: _____
List of Allergies:_____ Sex:_____
Requires EpiPen?: ❑No ❑Yes If yes: attach Allergy Action Plan

Physical Measurements		
Height:	Weight:	BMI:
BP:	Pulse:	

Screening Data
Scoliosis: ❑ No ❑ Yes Treatment:
Vision: Right: 20/ Left: 20/ Corrected:
Hearing: Right: Left: Corrected:
History of sickle cell disease or sickle cell trait: ❑ No ❑ Yes ❑ unknown

	WNL	Abnormal (list details)
Appearance		
HEENT		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Neurologic/psychiatric		
Skin		
Other		

Significant Medical History
Medical diagnoses:
Surgeries or significant injuries:
Hospitalizations:
Medications:
Mental health diagnoses:
Other?

REQUIRED: I have examined the above-named student and declare the following sports activities clearance:

SELECT ONE: ❑ Cleared-No Limitations

❑ Cleared with Limitations (list): _____

❑ Not Cleared (please explain): _____

Signature of healthcare provider: _____ Exam Date: _____

Printed name of healthcare provider: _____ **Must be after 05/01/2024**