



STUDENT NAME [FIRST & LAST]

DOB

## PHYSICAL EXAMINATION RECORD

ALL STUDENTS MUST HAVE A PHYSICAL EXAM THAT IS CURRENT [WITHIN 12 MONTHS] AT ALL TIMES TO PARTICIPATE IN SCHOOL PROGRAMS & ACTIVITIES.

EXAM DATE: \_\_\_\_\_ ALLERGIES \_\_\_\_\_

Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Height [inches] \_\_\_\_\_ Weight [pound] \_\_\_\_\_

Urinalysis \_\_\_\_\_

sugar \_\_\_\_\_

albumin \_\_\_\_\_

micro \_\_\_\_\_

Hemoglobin or hematocrit \_\_\_\_\_

Prior medical/psychological conditions \_\_\_\_\_

Previous musculoskeletal injuries \_\_\_\_\_

Current medical/psychological conditions \_\_\_\_\_

Psychotherapy or counseling history \_\_\_\_\_

**Asthma [If yes, please provide a copy of Asthma Action Plan]**

No  Yes  Intermittent  Mild Persistent  Moderate Persistent  
 Severe Persistent  Exercise Induced

**Anaphalaxis [If yes to food, please provide a copy of Food Allergy Action Plan]**

No  Yes  Food  Insects  Latex  Unknown Source

**History of Anaphalaxis**  No  Yes **Epipen Required**  No  Yes

## REVIEW OF SYSTEMS DESCRIBE FULLY [ USE ADDITIONAL SHEET IF NEEDED]

	WNL	ABNL
Head, ears, nose, throat		
Hearing		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		
Any other conditions		

Please list dose and schedule for each medication

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For returning students only: please list immunizations since last physical.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My examination finds the student named above to be in good health, free from contagion, and physically and emotionally qualified for a full program of study and sports.

Yes  No If no, please explain \_\_\_\_\_

Print or type name and address of examining physician \_\_\_\_\_

PHYSICIAN'S SIGNATURE [REQUIRED]

\_\_\_\_\_ DATE