



DON BOSCO TECHNICAL INSTITUTE

STUDENT PHYSICAL EXAMINATION FORM FOR SCHOOL YEAR 2024-2025

The following form must be completed by a certified medical examiner (e.g., M.D., D.O., or P.A-C.).

| | | |
|------------------------------------|---------------------|-------------------------------|
| STUDENT LAST NAME | STUDENT FIRST NAME | STUDENT IDENTIFICATION NUMBER |
| STUDENT DATE OF BIRTH (MM/DD/YYYY) | DATE OF EXAMINATION | NAME OF EXAMINER |

Vision: (OD) 20/ _____ (OS) 20/ _____ w/ Glasses or Contacts? Yes ___ No ___ Ht: _____ Wt: _____ Hearing (R) _____ (L) _____ w/Aids? Yes ___ No ___ Blood Pressure: _____/_____

REVIEW OF SYSTEMS: (REQUIRED)

Does student have normal color vision? _____

HEENT: _____

CHEST: _____

HEART: _____ MURMURS _____

ABDOMEN: _____

EXTREMETIES: _____

GENITALIA: _____ TANNER STAGE (I-VI) _____ CIRC: Y N

HERNIA: Y /N

NEUROLOGICAL: _____

BACK/SPINE PROBLEMS: _____

SCOLIOSIS: Y / N TYPE/DEGREE: _____

SKIN CONDITIONS/RASHES: _____

HX OF SERIOUS INJURIES/ILLNESSES: _____

SURGERIES:

IS STUDENT CLEARED FOR PHYSICAL EDUCATION AND COMPETITIVE SPORTS?

YES ____ NO ____

If no, please explain fully:

IS STUDENT CURRENTLY TAKING ANY MEDICATION OR BEING TREATED FOR ANY HEALTH PROBLEM OR ONGOING CONDITION? Y / N

If yes, please explain fully:

PLEASE LIST ANY ALLERGIES TO MEDICATIONS OR WRITE N.K.A.:

Examiner's Printed Name

Examiner's Signature & Title

Date