



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