DON BOSCO TECHNICAL INSTITUTE

STUDENT PHYSICAL EXAMINATION FORM FOR SCHOOL YEAR 2026-2027

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: ____/_____ Gender _____

REVIEW OF SYSTEMS: (REQUIRED)
Does student have normal color vision? _____

HEENT:_____

CHEST:_____

HEART: _____ MURMURS _____

ABDOMEN: _____

EXTREMETIES: _____

HERNIA: YES ____ NO _____

NEUROLOGICAL: _____

BACK/SPINE PROBLEMS: _____
SCOLIOSIS: YES ____ NO _____ 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? YES ____ NO _____

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