

HEALTH EXAMINATION FORM



1200 Oakdale Ave
West St. Paul, MN 55118
(651) 455-1521

Name: _____
(Last/Surname) (First/Given) (Middle)

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Grade: _____

Required for SPORTS:

I certify that the above-named student has been medically evaluated **with the following recommendations:**

- ☐ **YES** - The student is cleared for all sports and activities without restriction.
☐ **NO** - The student is not cleared for sports.
☐ The student is cleared for sports with the following restrictions: _____

	Normal	Abnormal
Eyes		
Ears		
Mouth – Dental		
Throat		
Nose		
Lymph Nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Hernia	☐ No	☐ Yes
Genito-Urinary		
Musculoskeletal		
Spine		
Extremities		
Skin		
Neurological		
Nutritional Status		
Emotional Status		
Behavior		

Height: ____ (ft) ____ (in) Weight: ____ (lbs)
 Blood Pressure: ____/____ Heart Rate: ____
 Vision: R 20/____ L 20/____ Correction: ☐ Y ☐ N
 Hearing: ☐ Normal ☐ Abnormal Hearing Aids: ☐ Y ☐ N

	500 (25)dB	1000 (20)dB	2000 (20)dB	4000 (20)dB
R				
L				

Allergies: _____

There is a condition that may result in an emergency:
☐ Yes ☐ No If yes, explain below.

There is a condition that may interfere with learning:
☐ Yes ☐ No If yes, explain below.

Females:

Age at first menstrual period? _____
 How many periods in the past 12 months? _____

Describe any abnormal findings or chronic conditions or attach documentation.

Health Concerns	Medications/Treatment/Referral Plan	Recommendations for School

Note: A separate form is required for all medications and treatments to be administered at school.

Signature and title of health care provider

Print Name

Date of Physical Exam

Clinic Name

Phone

Fax

Clinic Address

Email