REQUIRED PHYSICAL EXAMINATION FORM - School Year 2017-18

(Please Note: Physical Exam must be performed, signed & stamped by a licensed physician.)

Student: _____ **Grade:** _____ **Age:** _____ **Date of Birth:** _____

Sport(s): _____ **Sex: F** _____ **M** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Pulse:** _____ **Respiration:** _____

Vision: Corrected Right: _____ **Left:** _____

Uncorrected Right: _____ **Left:** _____ **Glasses/Contacts:** _____

RESULTS OF THE EXAMINATION: Check N for Normal or A for Abnormal (if abnormal explain)

	N	A	Comment		N	A	Comment
Eyes:	☐	☐	_____	Respiratory:	☐	☐	_____
General Appearance:	☐	☐	_____	Ears/Nose/Throat:	☐	☐	_____
Cardiovascular:	☐	☐	_____	Genital-Urinary:	☐	☐	_____
Head/Neck:	☐	☐	_____	Muscular-Skeletal:	☐	☐	_____
Neurological:	☐	☐	_____	Gastrointestinal:	☐	☐	_____
Allergy to Medication:	☐	☐	_____	Diabetes:	☐	☐	_____
Allergy to Dust:	☐	☐	_____	Seizures:	☐	☐	_____
Asthma:	☐	☐	_____	Concussion:	☐	☐	_____
Family History Sudden Death:	☐	☐	_____	Chest Pain:	☐	☐	_____

Physician's recommendation for Physical Education and/or Athletic Participation:

____ **Full Activity — (Cleared for unlimited participation)**

____ **Modified Activity — Please Explain:** _____

____ **No Activity Recommend:** _____

Remarks or Recommendation: _____

_____

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the candidate. I certify that all the important medical information has been included, and the information is complete and accurate.

Physician's Signature: _____ **Date:** _____

Physician's name (print): _____ **Physician's Stamp(Required):**

Physician's address: _____

Physician's Phone #: _____

9 GRADE AND TRANSFER STUDENTS NEED TO ATTACH A COPY OF UPDATED IMMUNIZATION RECORD*