Physical Form

Student Name: ____

Birthdate: ___/___/_____

Physical Examination: For Physician Use Only

A. Vital Statistics:

Gender: ❏ Male ❏ Female ***Ht.***_______ ***Wt.*** _________ ***Pressure*** ___/___ ***Temp.*** _____ ***Pulse*** _____

B. Health Examination: *Normal=N; Abnormal=A*

	Circle	Comments: Abnormal Findings; label by number
1. Appearance	N A	____
2. Skin/Nose	N A	____
3. Head/Scalp	N A	____
4. Eyes	N A	____
5. Visual Acuity (R&L)	N A	____
6. Ears	N A	____
7. Auditory Acuity (R&L)	N A	____
8. Nose/Throat	N A	____
9. Mouth, Teeth and Gums	N A	____
10. Chest/Lungs	N A	____
11. Heart	N A	____
12. Abdomen	N A	____
13. Genitals (optional)	N A	____
14. Musculo-Skeletal	N A	____
15. Neurological	N A	____
16. Alertness	N A	____
17. Emotional/Mental (Behavioral Problems)	N A	____
18. Handicap, Physical/Other (Specify)	N A	____
19. Activity Restrictions (Specify)	N A	____
21. Nutrition	N A	____
22. Other	N A	____

C. Health History: (serious illnesses, injuries: explain)____

D. Medications: (Please list all current medications) ____

E. Laboratory: (if clinically indicated) ____

F. Verification: (check all that apply)

❏ I certify that this student may participate in all university activities.

❏ I certify that this student may participate in inter-collegiate athletics.

❏ I certify that this student may participate in all university activities with the following exceptions _ and/or limitations:

G. ***General Comments****:*____

Physician's Name:__________________________________ Name of Clinic:_ __________________

Address:____ Phone #: (_____) ______-_________

Signature:_ _____ **Date**: _____