

PHYSICAL EXAMINATION

STUDENT INFORMATION

First Name	Middle Name	Surname or Family Name	Other

Height:	Weight:	Blood Pressure:	Hair Color:	Eye Color:
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Evaluation	Normal	Abnormal	Comments
Skin			
Nose			
Throat			
Teeth			
Cardiovascular			
Gastrointestinal			
Genital-Urinary			
Neurological			
Muscular Skeletal			
Scoliosis Screening			
Nutritional Status			

Does student have any allergies to foods, medications, other? Hay fever, Asthma, Eczema? If so, please list.


Does student take any daily/regular/routine medications? If so, please list.

Has the student been under a physician's care within the past two (2) years? If so, please describe.

Has the student any surgical procedures, significant injuries? Any sequelae? If so, please describe.

Has the student had a positive reaction to or been treated for HIV? If so, please describe.

Has the student in consultation with any doctor or counselor concerning use of controlled substances, emotional and psychiatric problems? If so, please describe.

Signature of Examining Medical Professional	Name of Business, Clinic or Facility	
		
Address	City, State	Zip or Postal Code