

Student Name: _____

FOR EXAMINING PHYSICIAN ONLY

General Information

Eyes: RT: _____ LT: _____ Corrected: Yes _____ No _____ BP: _____ Pulse: _____

Height: _____ Weight: _____

Examination	Normal	Abnormal	Labs:
Medical			
1. Head			
2. Eyes			
3. Ear/Nose/Throat			Medications:
4. Teeth			
5. Skin			
6. Lymphatic			
7. Lungs			
8. Heart			Allergies:
9. Abdomen			
10. Hernia			
Musculoskeletal			
1. Cervical/Spine/Neck			
2. Back			Approved for Sports? Yes: _____ No: _____ If no, explain...
3. Shoulders/Arms			
4. Elbow/Wrist/Hand			
5. Hip/Thigh/Knee			
6. Leg/Ankle			
7. Foot			
Other Joint Exam			Comments:

Date of Physical Exam: _____

Physician Signature: _____

Typed or Printed Physicians Name: _____

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