



THIS SIDE TO BE COMPLETED BY PHYSICIAN

Student's Name (PLEASE PRINT) \_\_\_\_\_

Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present Age:                    yrs.                    mos.	General Appearance			
Height (no shoes):            inches (            %)	Skin			
Weight (light clothing):      lbs.            oz. (            %)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	1) Reflex Test			
	2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck(lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Explanation of Abnormal Findings: \_\_\_\_\_

Scoliosis Screening: Pass \_\_\_\_\_ Fail \_\_\_\_\_ Refer \_\_\_\_\_ Comments: \_\_\_\_\_

Patient Health History, Findings and Recommendations:

\_\_\_\_\_  
\_\_\_\_\_

Physical Activity: Restricted or Unrestricted (circle one) Explanation:

\_\_\_\_\_

I have examined the child named on this form, and find that he/she is able to participate in the athletic and physical education programs of the school:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(stamped signature not accepted)

Please print physician's name and address: \_\_\_\_\_  
(MD / DO or PA or RNP working under the direction of a licensed physician)