



Physical Examination (required)

(Please print in black Ink)

(To be completed and signed by physician or clinic)

Last Name:	First name	Middle Name
Permanent Address:		
City:	State:	Zip:
Area Code/Phone Number:		Date of Birth (mm/day/yr):

Height		Weight		BP	/	Pulse		/min.
Vision:	Corrected	Right 20/		Left 20/		Hearing (gross) 15 ft.	Right	Left
	Uncorrected	Right 20/		Left 20/			Right	Left
Urinalysis					Hematocrit			
Sugar					%			
Albumin								
Micro								

Are there abnormalities?	Normal	Abnormal	Description (attach additional sheets if necessary)
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			
Mammary			

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IMMUNIZATIONS	mo./day/yr (#1)	mo./day/yr (#2)	mo./day/yr (#3)	mo./day/yr (#4)
DTP or Td(within the last 10 yrs)				
Td Booster				
Polio				
MMR (after first birthday)				
MR (after first birthday)				
Measles (after first birthday)				
Mumps				
Rubella				
BCG Vaccine				
Please note: A TB test is required and must be administered within the last 12 months. Tuberculin (PPD) Test Date Read (Within 12 months) mm induration Is the PPD negative or positive?				
Chest X-ray, if positive PPD, Date	Results			
Treatment, if applicable	Date			

A. Is there loss or seriously impaired functions of any paired organs? Yes No
Explain _____

B. Is student under treatment for any medical or emotional condition? Yes No
Explain _____

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _____ Limited _____
Explain _____

D. Is student physically and emotionally healthy? Yes No
Explain _____

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner	Date of examination:
Print Name of Physician/Physician Assistant/Nurse Practitioner	Area Code/Phone Number:
Office Address	City: State: Zip Code: