

TO THE EXAMINING PHYSICIAN

Patient's Name _____

PHYSICAL EXAMINATION: When answering these questions, please use the term NEGATIVE or NORMAL(N)

General Development: _____ Weight _____ Height _____

Blood Pressure _____ Pulse _____ Skin _____

Vision: Rt. / _____ Lt. / _____ Glasses: Rt. / _____ Lt. / _____

Head: Eyes _____ Ears (hearing) _____ Nose _____ Throat _____ Teeth _____

Neck: Thyroid _____ Nodes _____

Chest: Lungs _____ Breasts _____

Heart _____

Abdomen: _____ Hernia _____ Testes _____

Skeletal: _____

Vascular: _____

Neurological: _____

Other: _____

SUMMARY: _____

Student restricted _____ Not restricted _____ for varsity or any sports
(Statement must be checked if student plans to participate in varsity/other sports)

Physician's Signature _____

Print Physician's Name _____ Date: _____

Office Address _____ Phone: _____