

Physician's Report of Physical Examination

**\*\*CONFIDENTIAL\*\***

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_.

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

Glasses? \_\_\_\_\_ When last checked? \_\_\_\_\_.

Blood Pressure: S \_\_\_\_\_ D \_\_\_\_\_ Pulse \_\_\_\_\_/minute

	Normal Check	Abnormal Check	Remarks
Eyes	_____	_____	_____.
Ears	_____	_____	_____.
Nose	_____	_____	_____.
Mouth	_____	_____	_____.
Teeth	_____	_____	_____.
Throat	_____	_____	_____.
Neck	_____	_____	_____.
Heart	_____	_____	_____.
Lungs	_____	_____	_____.
Abdomen	_____	_____	_____.
Extremities	_____	_____	_____.
Neurological	_____	_____	_____.
Skin	_____	_____	_____.

Immunizations: See Immunization Record

Laboratory (Required)

Hemoglobin \_\_\_\_\_ Urinalysis: Sugar \_\_\_\_\_ Albumin \_\_\_\_\_.

Is this person physically and emotionally able to take regular classwork (including P.E.?)

Yes \_\_\_\_\_ No \_\_\_\_\_

If not, why not? \_\_\_\_\_.

HEALTH SUMMARY: Is there anything significant about this person that would aid us?

Please include current treatment or medications and condition for which prescribed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

Date \_\_\_\_\_

Signed \_\_\_\_\_.

Address \_\_\_\_\_.

Licensed in the State of \_\_\_\_\_.

Registration No. \_\_\_\_\_.