



# REPORT OF MEDICAL EXAMINATION

To be completed by Physician:

Family Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Results of Examination:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_)  
Vision: R 20/\_\_\_\_ L20/\_\_\_\_ Corrected: Y / N Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
<b>MEDICAL</b> Nose Mouth Teeth Pharynx Allergy Lungs Abdomen Genitourinary Hernia Orthopedic Posture Heart/Circulatory Congenital General Appearance			
<b>MUSCULOSKELETAL</b> Neck Back Shoulder/Arm Elbow/Forearm Wrist/Hand/Fingers Hip/Thigh Knee Leg/Ankle Foot/Toes			

Recommendations pertaining to physical education:

☐ Full Activity ☐ Modified Activity ☐ No Activity

Clearance for Interscholastic athletics:

☐ May participate ☐ May not participate

## New International Students Only:

	Type*	Date Given	Date Read	mm indur	Impression	CHEST X-RAY (Necessary if skin test positive)
<b>TB SKIN TESTS</b>	<input type="checkbox"/> PPD – Mantoux				<input type="checkbox"/> Pos	Film Date: _____ Impression: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
	<input type="checkbox"/> Other				<input type="checkbox"/> Neg	
	<input type="checkbox"/> PPD – Mantoux				<input type="checkbox"/> Pos	Person is free of communicable tuberculosis: <input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> Other				<input type="checkbox"/> Neg	
*If required for school entry, must be Mantoux unless exception granted by local health department.						

I certify that I have reviewed this health form and that the student has undergone a physical examination pertaining to disqualifying abnormalities of general physical qualifications, respiratory system, cardiovascular system, gastrointestinal system, musculoskeletal system and genitourinary system has been performed.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_