



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 |
|---|--------|-------------------|----------|
| MEDICAL Nose Mouth Teeth Pharynx Allergy Lungs Abdomen Genitourinary Hernia Orthopedic Posture Heart/Circulatory Congenital General Appearance | | | |
| MUSCULOSKELETAL Neck Back Shoulder/Arm Elbow/Forearm Wrist/Hand/Fingers Hip/Thigh Knee Leg/Ankle Foot/Toes | | | |

| |
|---|
| Recommendations pertaining to physical education: <input type="checkbox"/> Full Activity <input type="checkbox"/> Modified Activity <input type="checkbox"/> No Activity |
| Clearance for Interscholastic athletics: <input type="checkbox"/> May participate <input type="checkbox"/> May not participate |

New International Students Only:

| TB SKIN TESTS | Type* | Date Given | Date Read | mm indur | Impression | CHEST X-RAY (Necessary if skin test positive) |
|--|--|------------|-----------|----------|--|--|
| | <input type="checkbox"/> PPD – Mantoux <input type="checkbox"/> Other | | | | | <input type="checkbox"/> Pos <input type="checkbox"/> Neg |
| <input type="checkbox"/> PPD – Mantoux <input type="checkbox"/> Other | | | | | <input type="checkbox"/> Pos <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: _____