



ANNUAL PHYSICAL EXAM FORM

This section to be completed by a parent/guardian. Please print all information.

Student _____ Date of Birth _____ Grade _____

Please circle gender: Male Female

MEDICAL HISTORY

Allergies _____ Food allergy _____ Medication Allergy _____

Medical conditions/Illness we should be aware of: _____

Surgeries _____ Accident/ Injury _____

Is student taking **any** medication on a routine basis? Yes _____ No _____

List all medications and reason for taking: _____

Has student consulted with a specialist in the past 5 years?

Yes _____ No _____ If yes, please describe nature of condition: _____

This section to be completed by examining physician.

PHYSICIAN EXAMINATION:

Height _____ Weight _____ BMI _____ Blood Pressure _____ Pulse _____

	Normal	Abnormal		Normal	Abnormal
General Appearance			Cardiovascular		
Skin			Gastrointestinal		
Eyes			Genito-urinary		
Ears/Nose/Throat			Neurological		
Mouth/Dental Assessment			Developmental Screening		
Muscular			Nutritional Assessment		
Skeletal			Respiratory		

Are there concerns for this student's health? _____

Is the student capable of physical activity and participation in a competitive athletic program? _____ Yes _____ No

Are there any sports in which this student should not participate? _____

Are there any restrictions or activity limitations? _____

RECENT IMMUNIZATION DATES: (Please attach a vaccination record from your doctor's office)

Results of the physical exam completed by me on this date indicate that the individual named above is in good health.
Any problems to the contrary have been noted above.

Date _____ Examining Physician Signature _____

Physician's Name _____ Phone _____