# FOR EXAMINING PHYSICIAN ONLY

**General Information**

Student Name:_________________________

Eyes: RT:_______ LT:_______ Corrected: Yes_____ No_____ BP:________ Pulse:________

Height: __________ Weight: _________

| Examination | Normal | Abnormal | Labs: |
|---|---|---|---|
| **Medical** | | | |
| 1. Head | | | |
| 2. Eyes | | | |
| 3. Ear/Nose/Throat | | | **Medications:** |
| 4. Teeth | | | |
| 5. Skin | | | |
| 6. Lymphatic | | | |
| 7. Lungs | | | |
| 8. Heart | | | **Allergies:** |
| 9. Abdomen | | | |
| 10. Hernia | | | |
| **Musculoskeletal** | | | |
| 1. Cervical/Spine/Neck | | | |
| 2. Back | | | **Approved for Sports?** |
| 3. Shoulders/Arms | | | Yes:____ No:_____ |
| 4. Elbow/Wrist/Hand | | | If no, explain… |
| 5. Hip/Thigh/Knee | | | |
| 6. Leg/Ankle | | | |
| 7. Foot | | | |
| Other Joint Exam | | | **Comments:** |

**Date of Physical Exam: ___________________________________________**

**Physician Signature: ____________________________________________**

**Typed or Printed Physicians Name: ________________________________**