PHYSICAL EXAMINATION REPORT

STUDENT'S NAME _____
(last) (first) (middle initial) (phone)

_____
(address) (city) (state) (zip)

Date of Birth _____ Sex _____ Grade level in Sept. _____

Mother's Name _____ **Father's Name** _____

Address _____ Address _____

Phone _____ Phone _____

Student's Medical History
(to be completed by parent/guardian or physician)

	Yes	No	Date	**Description/Reason**
Allergies	❑	❑		
Asthma	❑	❑		
Blood Disorders	❑	❑		
Cancer	❑	❑		
Chicken Pox	❑	❑		
Diabetes	❑	❑		
Headaches	❑	❑		
Hearing Problem/Hearing Aid	❑	❑		
Heart Disease	❑	❑		
Hepatitis	❑	❑		
High/Low Blood Pressure	❑	❑		
Hospitalizations	❑	❑		
Kidney/Urinary Tract Problem	❑	❑		
Medication Reactions	❑	❑		
Menstrual Disorder	❑	❑		
Mononucleosis	❑	❑		
Muscular Disorder	❑	❑		
Orthopedic Disorder	❑	❑		
Rheumatic Fever	❑	❑		
Scoliosis	❑	❑		
Seizure Disorder	❑	❑		
Strep Infections	❑	❑		
Surgery	❑	❑		
Ulcer/Gastrointestinal Disorder	❑	❑		
Visual Problem/Glasses/Contact Lenses	❑	❑		
Other	❑	❑		

Is the student now under the care of a physician? _____

Does the student take any regular medication? Please name medication and dosage below.

_____

Has the student ever been advised by a physician not to play a sport? _____

Are there any other physical or emotional conditions that might bear on this child's abilities or performance?

_____

COMMENTS: _____

Parent/Guardian Signature: _____ Date: _____