PHYSICAL EXAMINATION (please print in black ink) **To be completed and signed by Physician**

Date of Examination MUST be within 6 months of the FIRST DAY OF CLASS.

			____/____/____	____/____/____
Last Name	**First Name**	**Middle Name**	**Date of Birth (month/day/year)**	**Examination Date**

HEIGHT _____ **WEIGHT**_____**Vital Signs: TPR**____/____/_____ **BP**_____/_____

(Specialist exams not required)

Vision: Corrected Right 20/_____
Left 20/_____
Uncorrected Right 20/_____
Left 20/_____
Color Vision

Hearing: (gross) Right _____
Left _____
15 ft. Right _____
Left _____

(Required tests)

Urinalysis: Sugar-_____Albumin _____

Micro_____

Hgb or Hct (if indicated) _____

Date Results_____ Recommendations _____

Are there abnormalities?	Normal	Abnormal	DESCRIPTION (attach additional sheets if necessary)
1. Head, Ears, Nose, Mouth, Throat			
2. Eyes (Include glasses: reading/continuous)			
3. Cardiovascular (Heart/Circulation evaluation)			
4. Respiratory (Airway/Chest and Lungs)			
5. PPD (If positive, chest x-ray_____Date)			Date_____/_____Results (If positive, attach report)
6. Abdominal			
7. Endocrine (Include thyroid problems/diabetes, etc.)			
8. Musculoskeletal/Neurological:			
a. Sensory (other than previously noted)			
b. Motor (condition of spine/extremities?)			
11. Skin (Include latex sensitivity)			
12. Rubella/Hepatitis Screen (If no immuniz. proof)			

A. Is there loss or seriously impaired function of any paired organs? Yes_____ No _____
Explain _____

B. Is student under treatment for any medical, psychological, or emotional condition? Yes_____No _____
Explain _____

C. Recommendation for physical activity. Unlimited _____ Limited _____
Explain _____

D. Is student physically, psychologically, and emotionally healthy? Yes_____ No _____
Explain _____

* Based on my assessment of this student's physical and emotional health on_____, he/she appears able to participate in all activities. Yes_____No_____If no, please explain _____

_____

X _____ _____
Signature of Physician Date

_____ _____
Print Name of Physician State License Number