Health Form

Physical Examination: Completed by licensed physician, licensed osteopathic physician, licensed chiropractic physician, licensed physician assistant, or certified advanced registered nurse practitioner

Student'sName:_____Date of Birth: ___/___/____
Height: _____ Weight:_____ % Body Fat: _____ Pulse: _____ Blood Pressure: ____ / ____
(____/____ , ____ /____) Temperature: _____Hearing: right: P _____ F _____ left: P _____ F _____
Visual Acuity: Right 20/_____ Left 20/_____ Corrected: Yes / No Pupils: Equal / Unequal

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL:			
1. Appearance			
2. Eyes/Ears/Nose/			
3. Lymph Nodes			
4. Heart			
5. Pulses			
6. Lungs			
7. Abdomen			
8. Skin			
MUSCULOSKELETAL:			
10. Neck			
11. Back			
12. Shoulder/Arm			
13. Elbow/Forearm			
14. Wrist/Hand			
15. Hip/Thigh			
16. Knee			
17. Leg/Ankle			
18. Foot			

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER: I hereby certify that each examination listed above was performed by me or an individual under my direct supervision with the following conclusion(s): ____ Cleared without limitation
____ Disability:_____ Diagnosis: _____
Precautions:_____
_____
Not cleared for:_____Reason:_____
Cleared after completing evaluation/rehabilitation for: _____
Referred to: _____For:_____
Recommendations:_____
_____

Name of Physician
(print):_____Address:_____Date:_____
_____ Physician/Physician Assistant/
Nurse Practitioner (Signature)