2017 - 2018 ANNUAL PHYSICAL EXAM FORM

Name: ______________________________ **Date of Birth:** __________

Height: _______ **Weight:** _______ **Pulse:** _______ **BP:** ______________

Vision: R 20/ _____ **L 20/** _______ **Glasses/Contacts: Yes No** **Pupils: Equal** ☐ **Unequal** ☐

	Normal	Abnormal	Describe abnormality in detail
Medical			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/ Oropharynx			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia/ Hernia			
Musculoskeletal			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

CLEARANCE

☐ Cleared for Physical Education

☐ Restricted (indicate) : ______________________________

☐ Not Cleared: ____________________ Reason: ____________________

Comments & Recommendations: ______________________________

____

Name of physician (print/type) ______________________________ Date ____________

Address ______________________________ Phone ____________

Signature of physician ______________________________ MD/DO/NP/PA-C