GENERAL PHYSICAL EXAMINATION FORM

Student Name:_____ Birth Date: _____ Grade: _____

Address: _____

Father's Name: _____ Mother's Name: _____

Significant History: _____

(This section to be filled out by examining physician)

Age: _____ Height: _____ Weight: _____ Eyes: R _____ L _____

Skin: _____ Mouth: _____ Teeth: _____ Ears: R _____ L _____

Nose: _____ Throat: _____ Tonsils: _____ Heart: _____

Back: _____ Spine: _____ Chest: _____ Abdomen: _____

Arms: _____ Legs: _____ Pulse: _____ Blood Pressure: _____

Nutrition: _____ Neurological: _____

Limitations: _____

_____

Comments: _____

_____

_____

I hereby certify that I have, on this date, examined the above student, and I have found no medical reason to disqualify him/her from participating in all supervised athletics and physical education activities, except for the limitations I have indicated.

Signature of Examining Physician: _____ **Date:** _____

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