

***** YEARLY PHYSICAL EXAMINATION by MD / DO / APRN / PA *****

NAME

DATE OF BIRTH

GENERAL EXAM	Normal	Abnormal Findings
Appearance		
Skin		
HEENT		
Respiratory		
Cardiovascular		
	Arrhythmia	
	Murmur	
Abdomen		
Spine		
Postural		Abnormal: Minimal
		Abnormal: Slight
		Referral: Mod
		Referral: Marked
Neurological		
Genitalia (hernia)		
Physical Maturity (Tanner State)	1 2 3 4 5	

Height		Weight	
B/P		Pulse	
Hct/Hgb		UA	
Gross Dental (teeth & gums)			
Vision:			
with glasses:	R 20/	L 20/	
without glasses:	R 20/	L 20/	
Type of screening:			
Auditory: Pass:	R:	L:	
Fail:	R:	L:	
Type of screening:			
Body Fat (Optional) =			
Cholesterol (Optional)=			
Immunizations:			
Last Tetanus booster:			
Last Measles (MMR) booster:			
Other:			

ORTHOPEDIC EXAM: Musculoskeletal Evaluation to include Range of Motion, Strength & Flexibility		
	Normal	Abnormal Findings
Neck		
Spine		
Shoulders		
Arms / Hands		
Hips		
Thigh		
Knees		
Ankles		
Feet		

SUMMARY:

RECOMMENDATIONS:	Weight Loss / Gain:
Strengthening:	Special Equipment:
Stretching:	Bracing / Taping:
Conditioning (Endurance):	Medications:

I certify that on this date I have examined (date of PE _____) this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities *except those listed below:* _____

MD / APRN / PA

SIGNATURE OF HEALTH CARE PROVIDER DATE TELEPHONE NAME (print or stamp) REV 2/04
 *****PHYSICAL EXAMINATION EXPIRES ONE YEAR FROM EXAM DATE*****