

# PHYSICIAN'S EXAMINATION

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

	Normal	Abnormal	Not Examined
Skin			
Eyes, vision, glasses			
Ears, hearing			
Nose and throat			
Mouth, teeth, speech			
Glands			
Chest, lungs			
Cardiovascular, heart			
Abdomen – enlargement			
tenderness			
hernia			
Spine, back			
Scoliosis – Grade 7			
Posture			
Extremities			
Genito-urinary			
Nervous System, reflexes			

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Nutritional status and general appearance of the child: \_\_\_\_\_

Recommendations for additional medical or dental care: \_\_\_\_\_

This student may participate in a normal physical education program which includes such activities as running, jumping, tumbling.  
 \_\_\_\_ Yes    \_\_\_\_ No

If a student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Address: \_\_\_\_\_