SCHOOL PHYSICAL EXAMINATION
West High School

HEALTH HISTORY (Must be completed and signed by parent prior to examination):

GRADE: _______ ATHLETIC PROGRAM IF STUDENT PARTICIPATES IN ATHLETICS: ________________________

Last Name | First Name | M.I. | Grade | Age | Birth Date | Male or Female

Address | City | Zip Code

HEALTH HISTORY (To be completed by student & parent):

Check **"yes"** or **"no"** and give as much information as possible.

______ Heart Trouble ________ High Blood Pressure ________ Asthma ________ Diabetes

______ Kidney Problems ________ Head Trauma ________ Seizures ________ Other

History of any previous injuries, fractures, serious illnesses or operations (Give year of problem)

Current medications | Allergies | Date of Last Tetanus Shot

Signature of Parent or Guardian: ____

PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN :

Visual Acuity (Distance): O.D.______/______O.S. ______/______ ( ) Corrected ( ) Uncorrected LMP______________

Ht ___________ Wt _____________ Temp ___________ B/P ____________ Pulse ___________ Respirations ___________

	Normal
1. Eyes	
2. Ears, Nose, Throat	
3. Mouth and Teeth	
4. Neck	
5. Cardiovascular	
EKG results if done	
6. Chest and Lungs	
7. Abdomen	
8. Skin	
9. Genitalia-Hernia (male)	

	Normal
10. Musculoskeletal ROM Strength	
Neck	
Spine	
Shoulders	
Arms/Hands	
Hips	
Thighs	
Knees	
Ankles	
Feet	
11. Neuromuscular	

SIGNIFICANT HISTORY FINDINGS:

( ) Chest Pain ( ) Extreme S.O.B. ( ) Dizziness ( ) Fatigue ( ) Palpitations ( ) Hx of family member w/ MI under 50yrs of age or Sudden Death of family member

Other: ____

RECOMMENDATION: ( ) Full Activity - No restrictions ( ) Activity with restrictions:____________________
( ) No contact sports ( ) No Participation
Other ____

EXAMINING PHYSICIAN:
Printed or stamped

Name:______________________________
Address:____________________________
LICENSE#: __________________________

Signature: __________________________
PHONE #: __________________________

DATE OF EXAM: ______________________________

Revised 08/10