



### PHYSICAL EXAM FORM

Student \_\_\_\_\_ Grade entering K \_\_\_ 5 \_\_\_ 7 \_\_\_

Sex M \_\_\_ F \_\_\_ Date of Birth \_\_\_\_\_

Parent(s)/Guardian \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

**To be completed by examining physician:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Visual Acuity: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ With Correction \_\_\_\_\_ Without Correction \_\_\_\_\_

**Physical findings significant to the school:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Classification physical activities:**

\_\_\_\_\_ Unrestricted activity  
\_\_\_\_\_ Moderate restriction (specify including duration):  
\_\_\_\_\_  
\_\_\_\_\_ Definitely restricted...Indicate type and duration on reverse side.

**Other recommendations or comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name (print) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/Zip Code \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_