PHYSICAL EXAMINATION – GRADES 5-8

RISING 6th GRADERS *MUST ATTACH IMMUNIZATION RECORDS*

THIS FORM MUST BE FILLED OUT AND SIGNED BY YOUR PHYSICIAN

Name _____ *Date _____
Temperature _____ Pulse _____ B.P. _____ Height _____ Weight _____

Key: √= normal; + = abnormal; + + = treatment needed

Posture		Hair		Thyroid	
Nutrition		Eyes		Heart	
Skin		Nose		Lungs	
Lymph Nodes		Ears		Abdomen	
Scars		Teeth		Liver	
Arms and Hands		Gums		Spleen	
Legs and Feet		Tongue		Kidneys	
Back		Tonsils		Hernia	

Remarks on Abnormalities:

_____

_____

List all drugs currently prescribed and dosage and reason for administration:

_____

_____

_____

Cleared without restriction

Cleared, with recommendations for further evaluation or treatment for:

_____

_____

_____

Not Cleared for All sports Certain Sports: _____ Reason:_____

Recommendations:

_____

_____

_____

Name of Physician (print/type) _____ Date: _____

Address _____ Phone: _____

Physician's Signature _____, MD or DO

***TO THE PHYSICIAN AND PARENT**: THIS EXAMINATION MUST BE PERFORMED IN 2017 AND SUBMITTED TO THE OFFICE ON OR BEFORE THE FIRST DAY OF SCHOOL.