PHYSICAL EXAM
2017/2018 School Year

Student ____ Grade entering K____5____7____

Sex M_____F_____ Date of Birth __________________

Parent(s)Guardian ____

Address ___________________________________ City ________________ Zip Code ________

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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:

____

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____

Classification physical activities:

__________ Unrestricted activity

__________ Moderate restriction (specify including duration):

____

__________ Definitely restricted…Indicate type and duration on reverse side.

Other recommendations or comments:

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Physician's name (print) ______________________________ **Phone** ______________________________

Address ______________________________ **City/Zip Code** ______________________________

Physician's signature ______________________________ **Date** ______________________