

St. Francis Central Coast Catholic High School
STUDENT PHYSICAL EXAMINATION

For Office Use Only
Student ID: _____

Last Name First Name Middle Name Birth date

Date of Examination

This form is to be completed by M.D., D.O., P.A., or Nurse Practitioner only

Vision: (R) 20/____ (L) 20/____ W/Glasses or Contact 20/____ Ht.____ Wt.____
Hearing: (R)____ (L) ____ W/Aids____ Yes__ No__ Blood Pressure__ /__

REVIEW OF SYSTEMS: Does Student have normal Color Vision? _____

Heent _____

Chest _____

Heart _____ Murmurs _____

Abdomen _____

Extremities _____

Genitalia _____ SMR# _____ CIRCLE Y N Hernia _____

Neurological _____

Back/Spine _____ Scoliosis _____

Skin Conditions/Rashes _____

HX. of serious injuries/illnesses _____

Surgeries _____

Is student cleared for physical education and competitive sports?
Yes _____ No _____ If no, please explain fully _____

Is student currently taking any medication or treatment for any health problem or ongoing condition? Yes _____
No _____. If yes, please explain fully, including medication and dosage: _____

Please list any medication allergies: _____

Physician's printed name

Physician's signature and title

