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: **Name:**_____ **Signature:** _____
Printed or stamped **Address:**_____ **PHONE #:** _____
LICENSE#: _____

DATE OF EXAM: _____

Revised 08/10