SOUTH ORANGETOWN CENTRAL SCHOOL DISTRICT

Physical Examination

PLEASE ATTACH IMMUNIZATION RECORD TO THIS FORM

Name: _____ DOB: _____ Sex: M ____ F____

MEDICAL SCREENING

Height: _____ Weight: _____ BMI: _____ BMI%: _____

Blood Pressure: _____ Pulse: _____

Urinalysis: _____ Vision: _____ Hearing: _____ Lead: _____

MEDICAL HISTORY/PHYSICAL EXAMINATION

Medical History: _____

Allergies: _____

History of Injury Past 3 Mos. Y☐N☐ ● History of Concussion Y☐N☐ ● Difficulty Breathing with Exercise Y☐N☐
Chest Pain With Exercise Y☐N☐ ● Dizzy Spells Y☐N☐ ● Severe Headache Y☐N☐ ● Current P.T. Y☐N☐

Medications:_____

ABNORMAL FINDINGS INDICATED ARE DESCRIBED BELOW

Eyes: _____Ears: _____Nose: _____Mouth: _____Dentition: _____Throat: _____Neck: _____

Thyroid: _____Chest: _____Lungs: _____Breasts: _____

Heart: Rate: _____Rhythm: _____Sounds: _____Murmur: _____

Abdomen: _____Genitalia: _____Tanner Stage: _____Lymph Nodes: _____Skin: _____

Extremities: _____Spine: _____Scoliosis: _____ Neurologic: _____

Abnormalities: _____

☐ All Findings Within Normal Limits

CLEARANCE

☐ May participate in all activities including P.E./Recess

☐ **<u>May</u> participate in all activities including the athletic competition categories which are <u>checked</u> below for the school year 20_____ - 20_____**

Contact/Collision ☐ ● Limited Contact/Impact ☐ ● Strenuous/Non Contact ☐ ● Non Strenuous/Non Contact ☐

Restrictions: _____

Exam Date: _____ Exam Valid Until: _____

_____ _____

Physician Signature Physician Stamp or Physician Name Printed