

■ **Part II: To be completed by physician and returned by July 1.** *Please respond to every line.*

Student's name \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_

Eyes: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Pupils equal Yes No

Ears \_\_\_\_\_ Hearing R+ L+

Nose \_\_\_\_\_

Mouth \_\_\_\_\_

Throat \_\_\_\_\_

Skin \_\_\_\_\_

Lymph nodes \_\_\_\_\_

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen: \_\_\_\_\_

Liver \_\_\_\_\_

Spleen \_\_\_\_\_

Hernia \_\_\_\_\_

Genitalia \_\_\_\_\_

Neurologic \_\_\_\_\_

Musculoskeletal: \_\_\_\_\_

Scoliosis \_\_\_\_\_

General assessment of muscular strength and flexibility \_\_\_\_\_

Required laboratory tests:

Urinalysis (required yearly) \_\_\_\_\_

**PPD (a baseline PPD within the past five years is required for all students)** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ Result: \_\_\_\_\_  
*month/year*

**PHYSICIAN'S STATEMENT**

I certify that I have on this date examined this student and find him physically able to compete in all supervised sports and activities except:

\_\_\_\_\_  
\_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_

*Physician*

**Physician's name, address, and telephone number (please print):** \_\_\_\_\_

\_\_\_\_\_

