ANNUAL PHYSICAL SCREENING

To Be Completed By Physician (Supplements Annual Physical Exam)

Student’s Name:

EXAMINATION:

Blood Pressure: Is this normal for individual?

Heart: Is this normal for individual?

Lungs: Is this normal for individual?

Eyes: Right Left \_

Hernia:

Lymph Nodes:

Orthopedic:

Thyroid:

Posture:

Nose:

Feet Mouth:

Skin (Non Comm.): Nervous Disorder: Reflexes: Deformities: Allergies:

Height:

Weight:

General Health: Good ( ) Fair ( ) Poor ( )

**Screenings:** Please do these screenings as part of the exam

Hearing Vision

Scoliosis Positive ( ) Negative ( ) Dental

Tests, If indicated:

Cleared for Physical Activity During School Hours? Yes ( ) No ( ) Restrictions:

Date Signature of Examining Physician

Physician’s name (print)