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 activities including P.E. / Recess

☐ **May participate in all activities including the athletic competition categories which are checked 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