

Bishop Montgomery High School

PHYSICAL EXAMINATION

Name _____ Date of Birth _____
Height _____ Weight _____
Pulse _____ Blood Pressure _____/_____(_____/____)(_____/____)
Vision: R 20/____ L 20/____ Corrected: Yes___ No___ Pupils: Equal___ Unequal ___

Medical

Ears _____
Nose _____
Throat _____
Lymph Nodes _____
Heart _____
Lungs _____
Abdomen _____
Skin _____
Genitalia (males only) _____

Musculoskeletal

Neck _____
Back _____
Shoulder/arm _____
Elbow/forearm _____
Wrist/hand _____
Hip/thigh _____
Knee _____
Leg/ankle _____
Foot _____

___ Cleared
___ Cleared after completing evaluation/rehabilitation for: _____

___ Not cleared for: _____ Reason: _____
Recommendations: _____

Name of physician (print/stamp) _____
Signature of physician _____ Date _____