Certificate of Examination (School Year)

Student Name _____ **D.O.B.** _____ **Grade** _____
Last First Middle M D Y

THIS FORM IS REQUIRED FOR THE FOLLOWING STUDENTS:
___ All New Students
___ All 6th grade students
___ All 9th grade students
___ Participation in ALL Interscholastic Sports (K-12)

To be completed by a Physician:

Height_____ Weight_____ Blood Pressure_____ Pulse_____

	N=Normal	A= Abnormal	Comment:: Abnormalities
1. Skin	N	A	
2. Head/Scalp	N	A	
3. Eyes	N	A	
4. Vision	N	A	
5. Ears	N	A	
6. Hearing (R/L)	N	A	
7. Nose/Throat	N	A	
8. Mouth/Teeth/Gums	N	A	
9. Chest/Lungs	N	A	
10. Heart	N	A	
11. Abdomen	N	A	
12. Musculo-Skeletal	N	A	
13. Neurological	N	A	
14. Nutrition	N	A	

15. Other health concerns (please specify)

On the basis of this examination, this student may participate fully in the school program, physical education class and interscholastic sports for one year.
Yes_____
No_____ (specify reason and restriction)

Physician's Signature: _____ Date:_____

Address: _____

_____

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