



PHYSICAL EXAM 2025-2026

Healthcare Provider to Complete

The Wellness Center will **NOT ACCEPT** a physical exam performed by a healthcare provider who is also the student's parent.

Student Name: _____ Date of Birth: _____

List of Allergies: _____ Sex: _____

Requires EpiPen?: ☐ No ☐ Yes **If yes: attach Allergy Action Plan**

Physical Measurements		
Height:	Weight:	BMI:
BP:	Pulse:	

	WNL	Abnormal (list details)
Appearance		
HEENT		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Neurologic/psychiatric		
Skin		
Other		

Screening Data		
Scoliosis:	☐ No ☐ Yes	Treatment:
Vision:	Right: 20/ Left: 20/ Corrected:	
Hearing:	Right: Left: Corrected:	
History of sickle cell disease or sickle cell trait:		
☐ No ☐ Yes ☐ unknown		

Significant Medical History
Medical diagnoses:
Surgeries or significant injuries:
Hospitalizations:
Medications:
Mental health diagnoses:
Other:

REQUIRED: I have examined the above-named student and declare the following sports activities clearance:

SELECT ONE:

☐ Cleared-No Limitations

☐ Cleared with Limitations (list): _____

☐ Not Cleared (please explain): _____

Signature of healthcare provider: _____ Exam Date: _____

Printed name of healthcare provider: _____

Must be after 05/01/2025