

PHYSICAL EXAMINATION - INTERSCHOLASTIC ATHLETICS

Last Name	First Name	Date of Birth	Grade
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Medical Examination Record for Interscholastic Athletics

Heart _____ Eyes _____

Ears _____ Nose & Throat _____

Lungs _____ Abdomen _____

Skin _____ Teeth _____

Blood Pressure (Sys) _____ Weight _____ Height _____

(Dia) _____

Other abnormalities _____

The above named student (is, is not) able to participate in interscholastic athletics.

Date Examined (Mo., Day, Yr.)

Doctor's Signature

School No.

Nurse's Initials After Entry

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