Annual Physical Examination
(To be completed by a licensed Healthcare Provider)

Student's Name: ___________________________________ Today's Date: ___________________

Height: ________ Weight: ________ B.P.: ___________ Pulse: ________ Temp: ________

Visual Acuity: O.D. _________ Corrected: ___________ O.S. _________ Corrected: ________

SYSTEM	Normal	Abnormal	Remarks (Describe Abnormalities)
Skin			
HEENT			
Hearing			
Thorax & Lungs			
Heart & Vascular			
Lymphatics			
Abdomen			
Genitourinary			
Musculoskeletal/Spine			
Neurologic			
Mental/Emotional			

Additional Comments:____

Provider Name: ________________________________ License #: _______________ State: ________

Signature: ____________________________________ Agency Name: _________________________

Agency Address: ______________________________ Agency Phone #: _______________________