

**Hope Lutheran School
Physical Evaluation**

Exam Date: _____

Name _____ Birth date _____ Age _____

Address _____ Phone _____

Grade and Year _____

A. PRE-PHYSICAL

Height _____ Weight _____ Blood Pressure _____

Vision Right _____ Vision Left _____ Glasses: YES/NO Contacts: YES/NO

Dental: Braces, Broken or missing teeth, plates, partials _____

B. GENERAL PHYSICAL

HEENT _____ HEART _____ LUNGS _____ ABDOMEN _____ HERNIA _____

C. ORTHOPEDIC EVALUATION

C-Spine _____ T-Spine _____ L-Spine _____ Hips/Pelvis _____ Knees _____

Feet/Ankle/Toes _____ Shoulders _____ Elbows _____ Wrists/hands/fingers _____

_____ Approved for athletic competition

_____ Disapproved for athletic competition, state reason _____

_____ Approved for athletic competition, refer to specialist for _____

_____ Disapproved for athletic competition, refer to specialist for _____

Signature of Physician

Telephone

Date

Print name of Physician

Address

Medical License Number

COMMENTS:

