



# Tri-City Christian Academy



## Physical Examination Form Athletics and Physical Education

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Significant History: \_\_\_\_\_

**(This section to be filled out by examining physician)**

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eyes: R \_\_\_\_\_ L \_\_\_\_\_

Skin: \_\_\_\_\_ Mouth: \_\_\_\_\_ Teeth: \_\_\_\_\_ Ears: R \_\_\_\_\_ L \_\_\_\_\_

Nose: \_\_\_\_\_ Throat: \_\_\_\_\_ Tonsils: \_\_\_\_\_ Heart: \_\_\_\_\_

Back: \_\_\_\_\_ Spine: \_\_\_\_\_ Chest: \_\_\_\_\_ Abdomen: \_\_\_\_\_

Arms: \_\_\_\_\_ Legs: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Nutrition: \_\_\_\_\_ Neurological: \_\_\_\_\_

Limitations: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I hereby certify that I have, on this date, examined the above student, and I have found no medical reason to disqualify him/her from participating in all supervised athletics and physical education activities, except for the limitations I have indicated.**

**Signature of Examining Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_