



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:** _____