Blue Mountain Academy

Physical Examination Form

(To be completed by a Health Care Provider)

Must be completed within 12 months prior to student's first day of school.

_____ _____ _____

Student's Name (Print) Birth Date Grade

_____ _____

Street Address City State Zip Home Phone

Allergies: _____

Significant Illness, Accidents, Operations, Congenital Defects, Family History, Etc.:

_____

_____

Height: _____ Weight _____ BMI _____ Vision Exam ☐ Check of corrective lenses

Pulse: _____ Resp: _____ B/P _____ Right Eye _____ Left Eye _____

PHYSICAL	NORMAL	ABNORMAL	FOLLOW-UP/COMMENTS
SKIN			
EYES			
EARS			
NOSE			
THROAT			
MOUTH			
CARDIOVASCULAR			
RESPIRATORY			
GLANDS			
GASTROINTESTINAL			
GENITOURINARY			
NEUROLOGICAL			
MUSCULAR SKELETAL			
SCOLIOSIS SCREENING			
NUTRITIONAL STATUS			
MENTAL STATUS			

I certify that I have examined this student on (date) _____. On the basis of this examination, I have found no reason that would make it medically inadvisable for this student to participate in supervised athletic activities.

_____ _____

Health Care Provider's Signature Health Care Provider's Name (Print)

_____ _____

Office Address City State Zip Office Phone