

RIVER CITY BELIEVERS ACADEMY



Physical Examination

Student's Name	Date of Physical:
Date of Birth	Telephone:

PHYSICAL EXAMINATION (Check if abnormal)

Temp	BP	Pulse	Ht (inches)	Wt (lbs)
Head	Teeth	Heart	Arms	Ears
Throat	Abdomen	Legs	Eyes	Neck
Genitals	Feet	Nose	Chest	Spine
Skins	Mouth	Lungs	Hands	Neuro

Please describe in detail any areas that were checked:

LABORATORY (if required)

Blood:	Hct:	Hgb:	Urine:	Protein:	Glucose:
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RESTRICTIONS IN ACTIVITY

Running:	Contact Sports:	No Physical Activity:	No Restrictions:
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Other:

PHYSICIAN'S PRINTED NAME:	PHYSICIAN'S SIGNATURE:
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Telephone:

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