

**OAK HARBOR SCHOOL DISTRICT
PHYSICAL EXAMINATION**

Name: _____ Age _____

HT: _____	B/P: _____
WGT: _____	Pulse: _____
UA: Pro. _____	Glu. _____
HCT or HGB: _____	
Visual Acuity: Left 20/ _____	
Right 20/ _____	

Preferred but Optional:

Peak flow:

X	Prior to run _____
X	Within 1 minute of run _____
X	Time of run _____
X	Pulse before run _____
X	Pulse after run _____

Normal / Abnormal

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Head _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Eyes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. ENT _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Teeth _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Chest _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Lungs _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Heart _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Abdomen _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Genitalia _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Neurologic _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Skin _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Physical Maturity _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Spine, Back _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Shoulders, Upper extremities _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Lower extremities _____ |

Assessment: Full Participation
 Limited participation (describe limitations, restrictions):

Participation contraindicated (list reasons):

Recommendations (equipment, taping, rehabilitation, etc.):

EXAMINER'S SIGNATURE: _____ Date of Exam: _____

Examiner's Name (print or stamp) _____ Examiner's Phone # _____