Southwestern Educational Society

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PHYSICAL EXAMINATION
(This form must be completed by a Doctor)

STUDENT'S NAME _____ GRADE _____

AGE _____ DOB:_____ FEMALE _____ MALE _____

WEIGHT _____ HEIGHT _____ VISION _____ HEAD _____

EARS _____ NOSE _____ THROAT _____ NECK _____

THORACIC: HEART _____ B/P _____ PULSE _____

LUNGS _____

GENITALS: _____

MENSTRUATION: _____

ABDOMEN: _____

EXTREMITIES: _____

GENERAL NEUROLOGIC: _____

IMPRESSIONS OR RECOMMENDATIONS: _____

HEALTH HISTORY OF THE CHILD

Epilepsy	yes ☐	no ☐		Diabetes	yes ☐	no ☐	
Hypertension	yes ☐	no ☐		Ulcers	yes ☐	no ☐	
Nervousness	yes ☐	no ☐		Kidney Problems	yes ☐	no ☐	
Headache/Migraine	yes ☐	no ☐		Heart Disease	yes ☐	no ☐	
Asthma	yes ☐	no ☐		Other Conditions	yes ☐	no ☐	

(If yes, please give more information)

ALLERGIES:_____

OTHER COMMENTS:_____

_____ _____ _____ _____
Print Doctor's Name LIC # Signature Date