

PHYSICIAN'S REPORT

No student will be allowed to attend class without health and immunization forms on file

(this is required by the state of Texas).

2025 - 2026



Name: _____ Grade: _____ Sex: _____ Birthdate: _____

Height: _____ IN. / _____ %tile.

Vital Signs:

Weight: _____ LBS. / _____ % tile.

Pulse _____ Resp _____ B/P _____

PHYSICAL EXAM Please describe any medical concerns identified and any curriculum adjustments required

General Posture, Gait _____

Nutrition _____

Skin _____

Nose, Mouth, Pharynx _____

Eyes: External/Optic Fund: _____

Ears: External and Canals _____

Tympanic Membranes _____

Frequent Earaches _____

Teeth/ Gums _____

Heart _____

Thyroid _____

Lungs _____

Abdomen (including Hernias) _____

Frequent Headaches _____

Bones, Joints, Muscles _____

Nervous System _____

SCREENINGS:

Spinal: _____
Vision: _____
Hearing: _____

ALLERGIES

Drug: _____
Food: _____
Other: _____

CLEARANCE

☐ Cleared
☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Not cleared for: _____ Reason: _____
Recommendations: _____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name(print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____ Signature: _____