LUTHER COLLEGE HIGH SCHOOL

PHYSICAL EXAMINATION CERTIFICATE

DATE OF EXAMINATION
Month / Day/ Year / /

TO BE COMPLETED BY EXAMINING PHYSICIAN *(Please print)*

NAME *First* *Middle* *Last*

DATE OF BIRTH *(Month / Day / Year)* / /

AGE

HOME ADDRESS

Gender – Male ☐ Female ☐

HEALTH HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Muscular Disease	☐	☐	Head or Spinal Injuries
☐	☐	Kidney	☐	☐	Psychiatric Disorder	☐	☐	Seizures
☐	☐	Tuberculosis	☐	☐	Gastrointestinal Disorder	☐	☐	Extensive confinement by illness or injury
☐	☐	Diabetes	☐	☐	Rx drug use	☐	☐	Musculoskeletal Injury
☐	☐	Nervous Stomach	☐	☐	Migraines/Headaches	☐	☐	Eye Disorders
☐	☐	Rheumatic Fever	☐	☐	Visual Disturbances	☐	☐	Epilepsy
☐	☐	Over the counter drug use	☐	☐	Learning disorders			
☐	☐	Permanent defect from illness, disease or injury						

IF ANSWER TO ANY OF THE ABOVE YES, EXPLAIN:

_____

GENERAL APPEARANCE AND DEVELOPMENT ☐ Good ☐ Fair ☐ Poor

VISION: For Distance: ☐ Right/20 ☐ Left/20 ☐ Both/20 ☐ Without Corrective Lenses ☐ With Corrective Lenses

Evidence of disease or injury: _____

Color Test: _____

HEARING: Right Ear _____ Left Ear_____

THROAT: _____

THORAX: Heart: _____ Pulse: ☐ Blood Pressure: ☐

Lungs: _____ TB Test: Neg.___ Pos. ___ Respirations per min. ☐

ABDOMEN: Scars_____ Abdominal Mass _____ Tenderness_____

MENSTRUATION CYCLE: Days ☐ Menses: _____/____/_____ *Month / Day/ Year*

GASTROINTESTINAL: Ulceration or other disease? Yes □ No □

LABORATORY & OTHER SPECIAL FINDINGS

Urine Spec. Gr. _____ | Albumin_____ | Sugar_____

Other Laboratory Data (Serology, etc.)

(please provide lab results)

GENERAL COMMENTS: _____

_____

_____
Name of Examining Doctor *(Please print)*

_____
Medical Doctor Signature

_____
Address of Examining Medical Doctor

Stamp