WEDGEFIELD UNIVERSITY

Physical Form

Student Name: ________________________________ **Parent's Name:** ___________________________

DOB: _________________________ **Grade:** _________________ **Date of Exam:** __________________

	NORMAL	ABNORMAL
Nutrition:	___	___
Gait:	___	___
Skin:	___	___
Eyes:	___	___
Nose:	___	___
Speech:	___	___
Throat:	___	___
Thyroid:	___	___
Lungs:	___	___
Bones and Joints:	___	___
Hemoglobin:	_______________	

	NORMAL	ABNORMAL
Posture:	___	___
Musculature:	___	___
Scalp:	___	___
Ears:	___	___
Mouth/Gums:	___	___
Teeth:	___	___
Lymph Nodes:	___	___
Heart:	___	___
Abdomen:	___	___
Feet:	___	___

Should physical activities be avoided? ___ Yes ___ No

Comments:

Examining Physician: ____________________________ Stamp and/or place of service: _________________

Signature