

DIOCESE OF DALLAS
PHYSICAL EXAMINATION

Student Name: _____

Please comment on any significant findings:

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Vision: Rt. 20 / _____ Lt. 20 / _____ w/Corr _____ Hearing: R _____ L _____

Abdomen _____ Limbs _____

Spinal _____ Bones & Joints _____ E.E.N.T. _____

Mouth _____ Teeth _____ Skin/Scalp _____

Chest _____ Reflexes _____

Heart & Circulation _____ Other _____

If there are any physical or emotional problems which may limit full school activity or that require special recommendations, please advise: _____

Additional Comments/Impressions: _____

PHYSICIAN'S SIGNATURE _____ DATE: _____

PHYSICIAN'S TELEPHONE NUMBER _____