CIVILIAN STUDENT TRAINING PROGRAM PHYSICAL EVALUATION

All Personally Identifiable Information Below is Protected by the Privacy Act and HIPAA.

Patient's Name: _____ **Date of Birth:** _____

Height: ____ **Weight:** _____ **Pulse:** _____ **BP:** _____

	Normal	Abnormal Findings	Provider Initials
Appearance			
Ears/Nose/Throat			
Vision	Right: 20/__ Left: 20/__	Pupils Equal: Y / N	
Lymph Nodes			
Heart			
Pulse			
Lungs			
Abdomen			
Genitalia			
Skin			
Neck			
Back			
Shoulders/Arms			
Elbows/Forearms			
Wrists/Hands			
Hips/Thighs			
Knees			
Legs/Ankles			
Feet			

Diagnoses

List all of the patient's medical diagnoses (If None, state "No Diagnoses"):

Do any of these diagnoses prevent him from activities of daily living or physical fitness? Y / N
If Yes, Please explain:

Clearance for Full Participation

___ Cleared ____ Not Cleared. If not cleared, state reason:

Current Prescription Medications

Medication Name	Reason for Rx	Dosage

Is the student current on all required immunizations? Y / N

Medical Facility:_____ Address: _____ Phone: _____

Printed Provider Name:

Provider Signature: Date of Physical: