

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:	