



PHYSICAL EXAMINATION FORM FOR FRESHMEN AND NEW STUDENT
(To be accomplished by a physician, NOT the PSHS Physician)

Full Name of Student

<ol style="list-style-type: none"> 1. Height _____ Weight _____ 2. Age _____ 3. Date of Birth _____ 4. Eyes : Vision test w/o glasses Distant _____ Near _____ O.D. _____ O.S. _____ 5. Ears: Canals R _____ L _____ Drums R _____ L _____ Hearing R _____ L _____ 6. Nose : _____ 7. Mouth and throat Tonsils: Present _____ Out _____ Teeth & gums : _____ 8. Neck : _____ Thyroid : _____ 9. Chest : _____ Chest X-ray (attach result pls.) 10. Breast : _____ 11. Heart : _____ 12. Pulse : _____ 13. Abdomen : _____ 14. Hernia : _____ 15. Genitalia : _____ Urinalysis : _____ 16. Back : (Scoliosis, etc.) _____ 17. Extrimitis : _____ Joints : _____ 18. Skin : _____ 19. Lymph Nodes : _____ 20. Nervous System : _____ 21. Complete Blood Count (Please attach result with this form) 22. Hepatitis B screening (HBs/Hg, anti-HBs) 23. (Please attach result with this form) 	<p>For examining physician:</p> <p>Comment on any physical or emotional problem which may prevent student from making a good adjustment to high school life or participate in athletics.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>How long has the student been your patient?</p> <p>_____</p> <p>_____</p> <p>Recommendation:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Name and Signature of Medical Examiner License No.: _____ Address: _____</p> <p>_____</p> <p>Date: _____</p>
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Please attach all the medical test results, listed below, with this form for submission to the PSHS Clinic.

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|-----------------|----------------|
| 1) CBC | 5) Chest X-Ray |
| 2) HBsAg | 6) Urinalysis |
| 3) HBsAb | 7) Fecalalysis |
| 4) Blood Typing | |