ISBVI Physical Exam Form
Academic Year 2020-2021

*****To be completed by a licensed healthcare provider*****

Name: _____ DOB: _____

Gender: ☐Male ☐ Female

Height:	Weight:	BP: /
Pulse:	Vision: R /20 L /20	Corrected: ☐YES ☐ NO

Examined Area	Normal	Abnormal Findings
Appearance		
Skin		
HENT		
Eyes		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
GU		
Musculoskeletal		
Neurologic		

Comments:

Please check one:

☐Cleared without restriction

☐Not cleared. Recommendations/modifications: _____

_____

_____

_____

I have examined the above-named student and completed the physical evaluation.

Printed Name of the MD/DO/NP/PA _____ Date: _____

Office Address: _____ Phone:_____

Provider Signature _____