

**DIOCESE OF DALLAS**  
**PHYSICAL EXAMINATION**  
**(REQUIRED)**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

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 \_\_\_\_\_