



The Canterbury Episcopal School

1708 N. Westmoreland Rd., DeSoto, TX 75115
(972) 572-7200 Fax: (972) 572-7400

Office Use Only	
Date Rec'd:	_____
Grade:	_____
Copy to:	LS _____
	MS _____
	US _____

Please Print or Type

2010/2011 Physical Examination Form

This Form is required for: **ALL NEW STUDENTS** - regardless of grade

This Form is Required for Students Incoming to Grades: **K, 1, 3, 5, 7, 9, 11**

This Form is Required Every Year for Participation in Sports for Grades: **6, 7, 8, 9, 10, 11, 12**

To Be Completed By Physician

Student Name: _____ Date of Birth: ___/___/___ Grade: _____

PHYSICAL EXAMINATION: _____ To be completed by Physician _____

HEIGHT WEIGHT BLOOD PRESSURE PULSE

Urine Test: HGB or Hematocrit _____
(Optional at Physician's discretion)

Hearing: R _____ L _____
Vision: R _____ L _____

- | | | |
|--------------------------|--------------------------|---------------------------------|
| Normal | Abnormal | |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes, Ears, Nose, Teeth, Throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Lungs / Chest |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdomen / Liver / Spleen |
| <input type="checkbox"/> | <input type="checkbox"/> | Genitalia (Male Only) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Spine |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

- | | | |
|--------------------------|--------------------------|--|
| Normal | Abnormal | |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbows |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrists |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Hips |
| <input type="checkbox"/> | <input type="checkbox"/> | Knees |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | Feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental: Cavities, Bridge, False Teeth
(Circle if applies) |

Description of any Abnormal Findings: _____

I certify on this date I have examined the above named student as indicated by items checked and recommend him / her as being physically able to participate in supervised activities as checked below:

_____ ALL Activities/Sports _____ MAY NOT PARTICIPATE in any Activity / Sports
_____ ACTIVITIES / SPORTS other than _____

Signature of Examining Physician _____ Printed/Stamped Name of Physician _____ Date _____