

Southeastern Louisiana University
 Dept of Kinesiology and Health Studies
 Physical Examination Form

Student's name: _____

SKIN				
EYES				
VISION				
EARS				
HEARING				
NOSE/THROAT				
NECK				
CHEST				
HEART				
ABDOMEN				
HERNIA				
EXTREMITIES				
NEUROLOGICAL				
MENSTRUAL HISTORY				
	BP	T	R	P
COMMENTS				

I hereby certify that I have reviewed this patient's information. I have examined this patient and have found them to be free of communicable diseases. I have reviewed their records and find them current on all required immunizations.

Physician's name: _____

Physician's signature: _____

Date: _____

