Clemson LIFE
COLLEGE OF EDUCATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of Birth: _____
Height: _____ Weight: _____ Pulse: _____ BP: _____
Vision: R20/ _____ L20/ _____ Corrected: Y ☐ N ☐ Pupils: Equal ☐ Unequal ☐

MEDICAL	Normal (Check)	Abnormal Findings (Please Specify)	Initials/Date
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart Murmur			
Pulse			
Lungs			
Abdomen			
Genitourinary (males)			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hands/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Cleared without restriction: _____ Date: _____
Not Cleared: _____ Cleared with specific restrictions (list)_____
Cleared with recommendations for further evaluation or treatment for:

_____

SIGNATURE OF PHYSICIAN: _____ Date: _____
Print Name and Address of Physician completing this form: