

Summer PHYSICAL EXAMINATION 2024

Student: Mr. Miss (Circle One)

Last

First

Middle

Preferred

Medical History

Health Concern:

Current Treatment:

Chronic Medical Illness:	
Emotional/Mental Health: (ie: OCD / Depression / ADHD / Anxiety)	
Eating Disorders: (ie: Anorexia / Bulimia / Purging)	
Environmental:	
Childhood Illnesses:	

Previous Injury

Old/New	Type of Injury	Location of Injury	Treatment

Do you have any concerns related to this student participating in an intensive, rigorous program of academic and artistic study? YES NO

If yes, please share any concerns that would assist us in caring for this student.

Physician Completing Form

_____		_____	
Physician's Name Printed		Physician's Signature	
_____		_____	
Practice Name		Date Exam Completed	

Mailing Address		City	State
_____		_____	_____
_____		_____	
Telephone Number		Fax Number	