Southeastern Louisiana University

Dept. of Kinesiology & Health Studies

Physical Examination Form

Student's Name: _____ W#: _____

Skin				
Eyes	**Right: /**		**Left: /**	
Vision				
Ears				
Hearing				
Nose/Throat				
Neck				
Chest				
Heart				
Abdomen				
Hernia				
Extremities				
Neurological				
Blood Pressure Stats	**/**	**Temp.**	**Resp.**	**Pulse**
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: _____