MISSOURI MILITARY ACADEMY ★ 1889 ★

PHYSICAL EXAMINATION

To be completed by medical professional

Date of Exam: _____ **Date of Birth:** _____

STUDENT INFORMATION

First Name	Middle Name	Surname or Family Name	Other

Height:	Weight:	Blood Pressure:	Hair Color:	Eye Color:

Evaluation	Normal	Abnormal	Comments
Ears			
Eyes			
Nose			
Throat			
Teeth			
Skin			
Cardiovascular			
Gastrointestinal			
Genital-Urinary			
Neurological			
Muscular Skeletal			
Respiratory			
Scoliosis Screening			
Nutritional Status			

Does the student have any allergies to foods, medications, other? Hay fever, Asthma, Eczema? If so, please list.

Does the student take any daily/regular/routine medications? If so, please list.

Does the student have any physical limitations? If so, please describe.

Has the student ever had Varicella disease? If so, please list month and year disease occurred.

Has the student been under a physician's care within the past two (2) years? If so, please describe.

Has the student had any surgical procedures, significant injuries? If so, please describe.

Has the student had a positive reaction to or been treated for HIV? If so, please describe.

Has the student in consultation with any doctor or counselor concerning use of controlled substances, emotional and psychiatric problems? If so, please describe.

Signature of Examining Medical Professional	Name of Business, Clinic or Facility	
Address	**City, State**	**Zip or Postal Code**