VCA Preseason Health Examination Form

(To be completed by Physician)

Student Name: _____ DOB: _____

Grade: _____ Age: _____ Height: _____ Weight: _____ Blood Pressure: _____

Contact lenses: _____ Full Time: _____ Near Vision Only: _____

Significant past or present illness, injury or allergies: _____

_____

_____

_____

System	Normal	Abnormal	Remarks
EENT			
Vision			
Hearing			
Lungs			
Heart			
Abdomen			
Neuro Muscular			

On the basis of this examination, I certify this student physically qualified for all sports EXCEPT the following:

_____

_____

Physician Signature: _____

Date: _____ Telephone: _____

Address: _____

_____

Physician Stamp: