

Summer Program Medical Physical Form

Student Name

Date of Birth

Gender

Home Address

Parent/Guardian Information
Name

Phone Number

Email

Physician Name

Physician Phone

Date of Physical Exam

Vital Signs

Height

Weight

Blood Pressure

Pulse

Allergies

Current Medications

Immunizations Up To Date?

Yes

No

If No, please list exceptions

Activity Limitations/Medical Conditions

Other Information

Examining Provider Name

License Number

Provider Signature

Date