

HIGHLAND CHRISTIAN SCHOOL SPORTS PHYSICAL

Student's Name _____

Date of Exam _____

Address _____

Date of Birth _____

Key

O - No Defect

/ - Slight Defect

X - Marked Defect

REQUIRED

RECOMMENDED

Height	Urine
Weight	Tonsils
General Posture	Nose & Throat
Heart	Eyes
Lungs	
Orthopedic	
Contagion	

Please indicate any athletic activities in which student should not participate _____

Physician's Signature _____