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