BUCKSPORT SCHOOL SYSTEM
Physical form

To be completed by physician:

Physician's name: (please print)_____
Student name: _____
Date of Birth: _____ Age: _____

Height: _____
Weight: _____
Pulse: _____
Blood Pressure: _____

Skin: _____
Eyes: _____
Ears: _____
Mouth: _____
Throat: _____
Teeth: _____
Neck: _____
Lungs: _____
Heart: _____
Abdomen: _____
Hernia: _____
Back: _____
Orthopedic: _____

Are immunizations up to date? _____
If any given please list: _____

I hereby certify that this student was examined by me and found physically fit to engage in athletic activities.

Date: _____Signature: _____

Comments:
_____
_____
_____

*__**ALL ATHLETES MUST HAVE AN UPDATED PHYSICAL EVERY TWO YEARS.**__
*__**RECOMMENDED AT THE BEGINNING OF GRADES 6,8,10, AND 12.**__