Holston United Methodist Home for Children

Physical Form to Be Completed by Physician

Name: ______________________________________ Gender: M F Date of Birth: ___/___/___
Father's Name: (If applicable): _________________________
Daytime phone, pager, cell phone: _________________________
Mother's Name: (If applicable): _________________________
Daytime, phone, pager, cell phone: _________________________

Address: ____

Home phone: ________________________

Alternate Emergency Contact Person: ______________________
Daytime phone: _______________________

Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.:
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PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height __________ Weight __________ Pulse __________ Blood Pressure __________

Normal Abnormal Findings Initials

1. Eyes
2. Ears, Nose, Throat
3. Mouth & Teeth
4. Neck
5. Cardiovascular
6. Chest & Lungs
7. Abdomen
8. Skin
9. Genitalia-Hernia (male)
10. Muskuloskeletal: ROM, strength, etc.
    a. neck
    b. spine
    c. shoulders
    d. arms/ hands
    e. hips
    f. thighs
    g. knees
    h. ankles
    i. feet
11. Neuromuscular

Please Print/ Stamp
Physician's Name ____
Street Address ____
City, State, Zip Code ____
Telephone ____

I certify that I have examined this person and found him/her medically qualified to participate in volunteer activities at Holston Home for Children with the following restrictions listed below.. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

PARTICIPATION RESTRICTIONS:
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____
____
____

Physician Signature ____

Date __________________