Seoul Foreign School
39 Yeonhui-ro 22-gil, Seodaemun-gu
Seoul, Korea 03723
Health Office Tel: 02-330-3203 / FAX: 02-333-5027
E-mail: sfsnurseoffice@seoulforeign.org

**** Please return this form to Health Office after completion.***

PHYSICAL EXAM FOR SPORTS

Student's Name (LAST, First, Middle)	Student ID#	Grade/Year	Date of Birth (mm/dd/yyyy)
_____	_____	_____	_____

Please complete this form using the following key: (N) Normal (SR) See Report

BP _____/_____**mmHg** **Height** _____ **Weight** _____

Nutritional Status: _____ **Skin:** _____

Eyes: _____ **sclera** _____ **pupils** _____ **vision: R**_____ **L** _____ **Corrective lens:** ☐ **Yes/** ☐ **No**

Ears: _____ **canals: R**_____ **L** _____ **drums: R**_____ **L** _____ **hearing: R** _____ **L** _____

Nose: _____ **septum** _____ **turbinates** _____

Mouth: _____ **lips** _____ **tongue** _____ **pharynx** _____

Teeth: _____ **gingiva** _____ **Throat:** _____ **shape** _____ **symmetry** _____

Neck: _____ **mobility** _____ **lymph nodes** _____ **thyroid** _____

Lungs: _____ **Heart:** _____ **rate** _____ **rhythm** _____ **murmur** _____

Abdomen: _____ **liver** _____ **spleen** _____ **hernias** _____

Lower Extremities: _____ **range of motion** _____ **development** _____ **strength** _____

Upper Extremities: _____ **range of motion** _____ **development** _____ **strength** _____

Spine: _____ **Neurological exam:** _____ **Attention Deficit Disorder:** _____

Significant Medical History _____

_____

Physician's Comments

_____

_____

Please administer the following tests IF NEEDED or REQUESTED BY PARENT.
(필요하다고 판단되거나 부모가 요청하는 경우에는 아래 검사를 실시해 주십시오.)

URINALYSIS (results) _____

HEMOGLOBIN (results) _____

OTHERS (results) _____

I certify that this student has been examined by me. This examination shows that this student is physically able to participate in physical education activities, including inter-scholastic sports, unless otherwise specified above.

Physician's Name: (please print) _____
** Please note that SFS does NOT accept a student's physical exam certified by a parent who may be a physician or medical professional.*

Physician's Signature: _____ **Date** (mm/dd/yyyy): _____

Name of Clinic/Hospital Stamp: _____ **Telephone:** _____