

ALASKA MILITARY YOUTH ACADEMY PHYSICAL EXAMINATION FORM

PURPOSE: The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioner **will not** be accepted. You may substitute this form but any substitution should include all the required information below. **A school sports physical will be accepted.**

Applicants Name (LAST, FIRST, MI) _____, _____, _____ **Date:** _____

Gender: ___ Male ___ Female **Date of Birth:** _____ **Age:** _____

Height: _____ **Weight:** _____ **P:** _____ **R:** _____ **B/P:** _____

Immunizations Current: ___ Yes ___ No → If not, why? _____

Vision R 20/ _____ **L 20/** _____ **Corrected?** ___ No ___ Yes

Allergies: _____

Normal	Abnormal	Area	-	Normal	Abnormal	Area
		HEAD, FACE, NECK, SCALP	-			VASCULAR SYSTEM
		EARS – GENERAL	-			ABDOMEN & VISCERA (include hernia)
		DRUMS (PERFORATION)	-			ENDOCRINE SYSTEM
		NOSE	-			G-U SYSTEM
		SINUSES	-			UPPER EXTREMITIES
		MOUTH & THROAT	-			FEET
		EYES – GENERAL	-			LOWER EXTREMITIES
		OPHTHALMOSCOPIC	-			SPINE, OTHER MUSCULOSKELETAL
		PUPILS	-			IDENTIFYING BODY MARKS, SCARS, TATTOOS
		OCULAR MOTILITY	-			SKIN, LYMPHATIC
		LUNGS & CHEST	-			NEUROLOGICAL
		HEART	-			PSYCHIATRIC

- Cleared for Full Participation – No Restrictions
- Cleared after completing evaluation / rehabilitation for: _____
- Cleared for Participation with the following accommodations for: _____
 - Diagnosis: _____
 - Treatment Plan / Accommodations: _____
- Not cleared for: _____ Reason: _____

PHYSICIAN NAME: _____ Signature: _____

Physician Phone#: _____ Fax: _____ Email: _____

Address: _____