

Thunderbird Youth Academy

Physical Exam

Patient Name: _____	Date _____
DOB: ___/___/___	
Vision	
Right 20 / _____	
Left 20 / _____	
(NOTE: THIS FORM IS TO BE COMPLETED ONLY IF YOU HAVE BEEN INTERVIEWED & ACCEPTED INTO THE ACADEMY)	

BP ___ / ___ P ___ Ht ___ Wt ___ Hair Color ___ Eye Color ___

Allergies _____	Conditions _____	Eyeglasses _____
_____	_____	Contacts _____
_____	_____	Dental _____
_____	_____	Other _____

Current Medications _____ HCG: Neg _____
 _____ Pos _____

Normal		Abnormal	Comments
	Skin / Tattoos		
	Mouth - Throat - Teeth		
	Nose -Sinuses		
	Ears		
	Eyes		
	Lungs		
	Heart		
	Abdomen		
	Extremities		

_____ is qualified for OKNG Challenge Program

_____ is not qualified for OKNG Challenge Program

If not qualified list reasons: _____

Printed name of Physician: _____

Signature of Physician: _____