

**Faith in Action Volunteers, Inc.**  
**Physical Examination Form**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ DOB: \_\_\_\_\_

History of Illness, Injuries and/or Operations:

\_\_\_\_\_

Vision: R Eye \_\_\_\_\_ L Eye \_\_\_\_\_ Hearing \_\_\_\_\_

Head, Neck, Ears, Nose and Throat: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Chest, Heart and Lungs: \_\_\_\_\_

Gastro-Intestinal Tract: \_\_\_\_\_

Kidneys and Urinary System: \_\_\_\_\_

Extremities: \_\_\_\_\_

Evidence of contagious or infectious disease: \_\_\_\_\_

Do you feel there is any physical or mental health reason why this person could not begin or continue to serve as a transportation / respite volunteers? NO \_\_\_\_\_ YES \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Restrictions and/or Limitations: \_\_\_\_\_

Date: \_\_\_\_\_ Location of Exam \_\_\_\_\_

Signature of Health Care Professional: \_\_\_\_\_