

2026 PHYSICAL EXAMINATION CERTIFICATE

FOR DEPARTMENT USE ONLY

Last Name _____ First Name: _____ Boys State # _____ City _____ County _____

APPLICANT NAME AND MAILING ADDRESS

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PERSONAL HISTORY: Indicate if the participant has ever had any of the following:

Injuries: _____

Allergies: _____

Medications: _____

Special Dietary Requirements related to food allergies, food intolerance or gastrointestinal disease:

Health Insurance Carrier: _____ Group & ID #: _____

Personal Physician: _____ Telephone (with area code): _____

TO BE COMPLETED BY PARENT/GUARDIAN - Person to notify in case of an emergency:

NAME: _____ PHONE: _____

ADDRESS:

NOTE TO PARENT OR GUARDIAN: In order to quickly procure any emergency care that may be necessary for the candidate and to protect the physicians and institutions involved, please complete and sign below:

Parent/Guardian Signature

Date

____ Parent ____ Guardian __ (check one)
REV 10/8/2025

NAME _____ DOB: _____

ATTENTION PHYSICIAN: Boys' State, by nature, is strenuous – both physically and emotionally. Therefore, the ability to cope adequately with these conditions should be seriously considered when completing this form.

Dates of: Td or Tdap Booster _____ MMR: _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Hearing: _____

Visual Acuity: _____ R _____ L _____

CLINICAL EXAMINATION

(Check each item in proper column. Enter NE if not evaluated.)

NORMAL ABNORMAL COMMENTS

1. Eyes	_____	_____	_____
2. Ears, Nose, Throat	_____	_____	_____
3. Hearing	_____	_____	_____
4. Mouth/Teeth	_____	_____	_____
5. Cardiovascular	_____	_____	_____
6. Chest/Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Genitourinary	_____	_____	_____
9. Musculoskeletal	_____	_____	_____
10. Metabolic	_____	_____	_____
11. Neurological	_____	_____	_____
12. Skin	_____	_____	_____
13. Lymphatic	_____	_____	_____
14. Psychiatric	_____	_____	_____

Does this boy have any physical limitations or restrictions which would hinder his participation in Boys' State?
Yes _____ No _____ (If yes, please explain. Attach additional sheets if necessary)

Physician's Signature: _____ Date: _____

Address: _____

Phone: _____